

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MD
4412

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04405

1. PLACE OF DEATH e. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg. P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanatorium & Hospital		d. STREET ADDRESS 6512 Westmorland Ave.	
3. NAME OF DECEASED (Type or print) Michael Stewart Alderman		4. DATE OF DEATH Month Apr. Day 25 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 9 yrs.
11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerry Alderman		14. MOTHER'S MAIDEN NAME Judith Jordan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hosp. Record.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHIXIA DUE TO Conditions, if any, which gave rise to immediate cause (b) APPARENTLY STRANGULATION (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASPIRATION OF GASTRIC CONTENT AND PULMONARY ATELECTASIS			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. (EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found in bed with venetian blind cord about neck			
20c. TIME OF INJURY Month, Day, Year 3:10 p.m. 4/24/61		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Takoma Pk. P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 25 1961	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/27/61	
22c. NAME OF CEMETERY OR CREMATORY ST MARY'S CEMETERY'S		22d. LOCATION (City, town, or country) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR W. J. Thompson		24a. REC'D BY REGISTRAR 5932	
ADDRESS 5932 Georgia Ave N.W.		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	
DATE APR 27 '61			

100-100000

(M)

(1)

100-100000

WASHINGTON, D.C.

ST. PAUL'S CATHEDRAL

100-100000

100-100000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04406

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1 yr. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheaton Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 7900 Cypress Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAE FORD ANDERSON		4. DATE OF DEATH Month Day Year April 22 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 27, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (retired)		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Ford	
14. MOTHER'S MAIDEN NAME Carrie Bramble		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Nursing Home Record Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 903.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Fracture of Left Hip DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.V.A. 1 yr. Reported Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 18 hours 18 hours
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor after leaving bathroom at Nursing Home	
20c. TIME OF INJURY Month Day Year 4/22/61 Hour a.m. 3 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home	20f. (City or town) (County) (State) Wheaton Montgomery Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/23/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL	22b. DATE THEREOF 4/26/61	22c. NAME OF CEMETERY OR CREMATORY MORROW CEMETERY	22d. LOCATION (City, town, or country) (State) MORROW, OHIO
23. FUNERAL DIRECTOR WINNER E. PUMPHREY, INC. <i>Raymond E. Jiska</i>		24a. REC'D BY REGISTRAR DATE APR 26 '61	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>

MEDICAL CERTIFICATION

THE
UNITED STATES

(M)

(I)

RECEIVED
JAN 10 1941
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Name: [illegible]
Age: [illegible]
Sex: [illegible]
Race: [illegible]
Date of Death: [illegible]
Place of Death: [illegible]
Cause of Death: [illegible]
Manner of Death: [illegible]
Signature: [illegible]
Date: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 05716

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Washington, D.C.</u> <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>Washington, D.C.</u> 47X3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carron Hall Kensington Sanitarium</u>		d. STREET ADDRESS <u>3100 Wisconsin Ave. N.W.</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>ARNOLO</u> Last <u>ARNOLO</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 JAN. 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Janeann Dickson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u> INFORMANT <u>RECORDS</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>692.5</u> DUE TO <u>pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>thrombophlebitis</u> DUE TO <u> </u> (c) <u>cellulitis right foot</u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic cardiovascular disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-2</u> , 19 <u>60</u> , to <u>4-30</u> , 19 <u>61</u> , that I lost saw the deceased alive on <u>4-28</u> , 19 <u>61</u> , and that death occurred at <u>7⁰⁰</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4701-Mass. Ave. N.W.</u> DATE SIGNED <u>4-30-61</u> ACTUAL SIGNATURE <u>Russell M. Tilly, D.</u> M.D. <u>Wash. D.C.</u> PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5-1-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 300-4th St. NW</u>		24a. REC'D BY REGISTRAR <u>Wash DC</u> DATE <u>MAY 3 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

NEGATIVE FOR 2 AMPLIFIN

BE 6002

W. J. B. B. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6806 10th Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Marius Ashton</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-09</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>office mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Robert K. Ashton</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-2688</u>	
17. INFORMANT <u>Mrs Ruth Ashton</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency - - minutes</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>severe generalized coronary atherosclerosis -years.</u> cause last, stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		DATE SIGNED <u>4-13-61</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 17, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	22d. LOCATION (City, town, or country) (State) <u>Montgomery County Md</u>
23. FUNERAL DIRECTOR <u>Arthur L. Jones</u>		24. REC'D BY REGISTRAR <u>APR 18 '61</u>	
ADDRESS <u>254 CARROLL ST. N.W. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Jones</u>	

1. The first section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

2. The second section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

3. The third section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

4. The fourth section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

5. The fifth section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

6. The sixth section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

7. The seventh section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

8. The eighth section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

9. The ninth section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

10. The tenth section of the act provides that the Secretary of the Interior shall have the honor to receive and receive the same from the Secretary of the Treasury.

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hours after
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04408

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6308 Bells Mill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry C. Atkinson 4. DATE OF DEATH April 1 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6/22/98 9. AGE (In years last birthday) 62 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Aid to the Blind 11. BIRTHPLACE (County & State, or foreign country) Richmond, Va 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Yes-Unknown 17. INFORMANT Unknown Address		14. MOTHER'S MAIDEN NAME Unknown 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Osteomyelitis, right tibia, chronic 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 3/24/61 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Bethesda (County) Montgomery (State) Md.		21. I certify that (I) (this hospital) attended the deceased from 3/24/61 , 19 61 , to 4/1/61 , 19 61 , that (I) (we) last saw the deceased alive on 3/31/61 , 19 61 , and that death occurred at 12:45 , from the causes and on the date stated above. 22a. SIGNATURE Robert N. Coale M.D. 22c. PHYSICIAN'S NAME (Type) Robert N. Coale 22b. DATE SIGNED 4/1/61 22d. ADDRESS 4630 Montg. Ave. Bethesda, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/4/61 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. 23d. LOCATION (City, town or county) Silver Spring, Maryland (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 5 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



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Robert A. Murphy, Bethesda, Maryland
Care of Messrs. C. & G. River, River Station, Maryland
1000 North Ave. Bethesda, Md.
1000 North Ave. Bethesda, Md.

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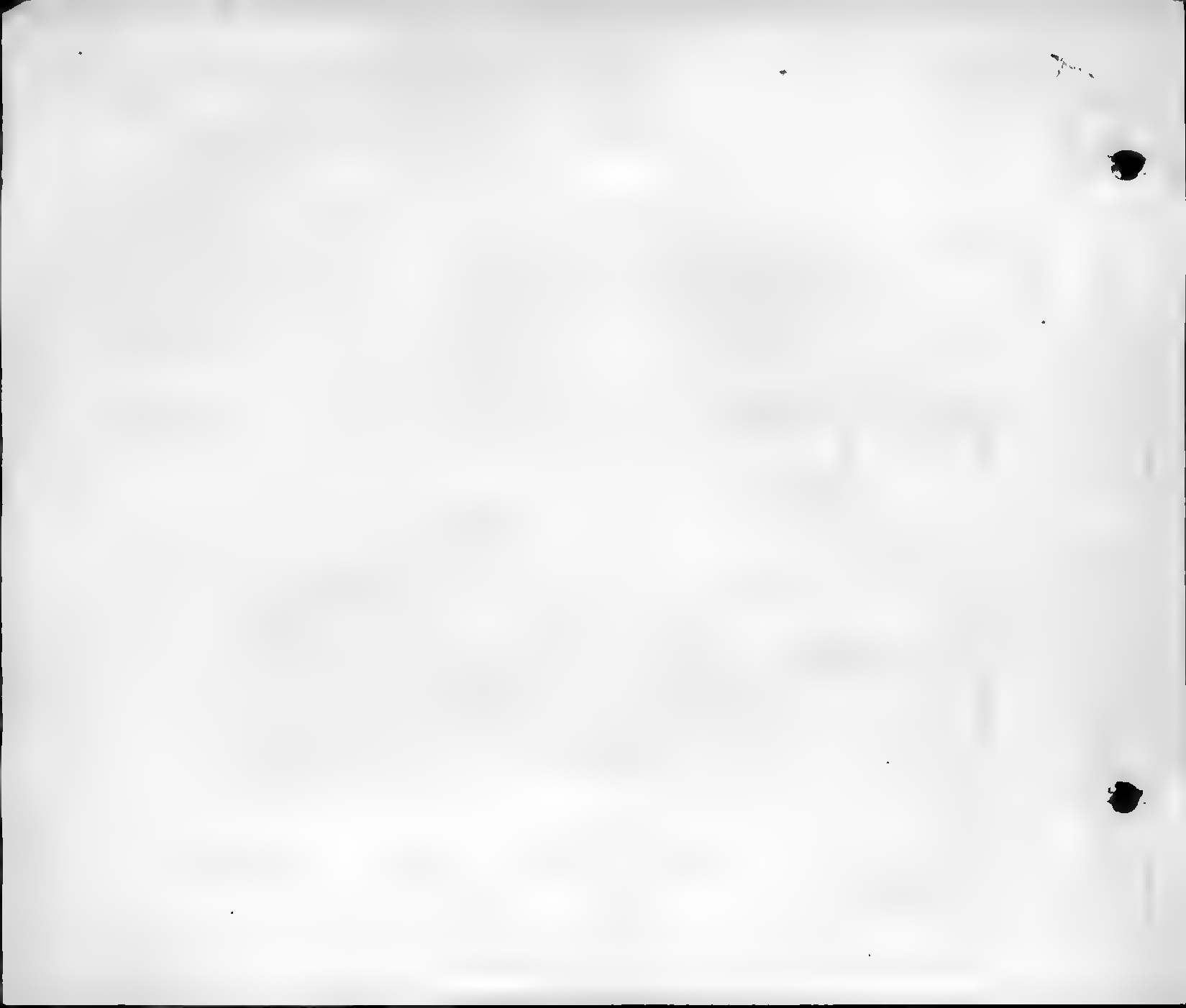
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04499

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6002 Coral Sea Ave</u>				d. STREET ADDRESS <u>6002 Coral Sea Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Emily</u> First <u>None</u> Middle <u>Austin</u> Last				4. DATE OF DEATH <u>April</u> Month <u>27</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 23, 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u> Hours <u>19</u> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles Day</u>				14. MOTHER'S MAIDEN NAME <u>Ann Low</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>			
17. INFORMANT <u>Mrs. R.H. Standing</u> Address <u>6002 Coral Sea</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 yrs</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic H.D. & atherosclerotic infarction</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug</u> 19 <u>60</u> to <u>April</u> 19 <u>61</u> , that I last saw the deceased alive on <u>April 24</u> 19 <u>61</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herman Chaganzini</u> M.D.				ADDRESS (Street, city or town, state) <u>809 Veirshmill Rd, Rockville, Md.</u>			
DATE SIGNED <u>4/27/61</u>							
PHYSICIAN'S NAME (Type) <u>Herman Chaganzini</u>				<u>Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAY 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4413

04410

Item 7 Film 3285

4/24/61 ink

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownack</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Washington Southern Hospital</u>		d. STREET ADDRESS <u>12910 Colesville Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROLINE O BAKER</u>		4. DATE OF DEATH Month Day Year <u>April 14 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. FUNDERS YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Bell Aire, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>----- Osterkamp</u>		14. MOTHER'S MAIDEN NAME <u>Marg Stanger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>-----</u>	
17. INFORMANT <u>Mrs. Edith B. Keller</u>		Address <u>12910 Colesville Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>31X</u> (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 21 1960</u> to <u>April 14 1961</u> , that (I) (we) last saw the deceased alive on <u>April 13 1961</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Arnon H. Traum</u>		22b. DATE SIGNED <u>April 14 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARNON H. TRAUM</u>		22d. ADDRESS <u>8237 Georgia Avenue Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 17-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Crownack</u>		23d. LOCATION (City, town, or county) (State) <u>Belleville - Montg. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>APR 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>			

MEDICAL CERTIFICATION

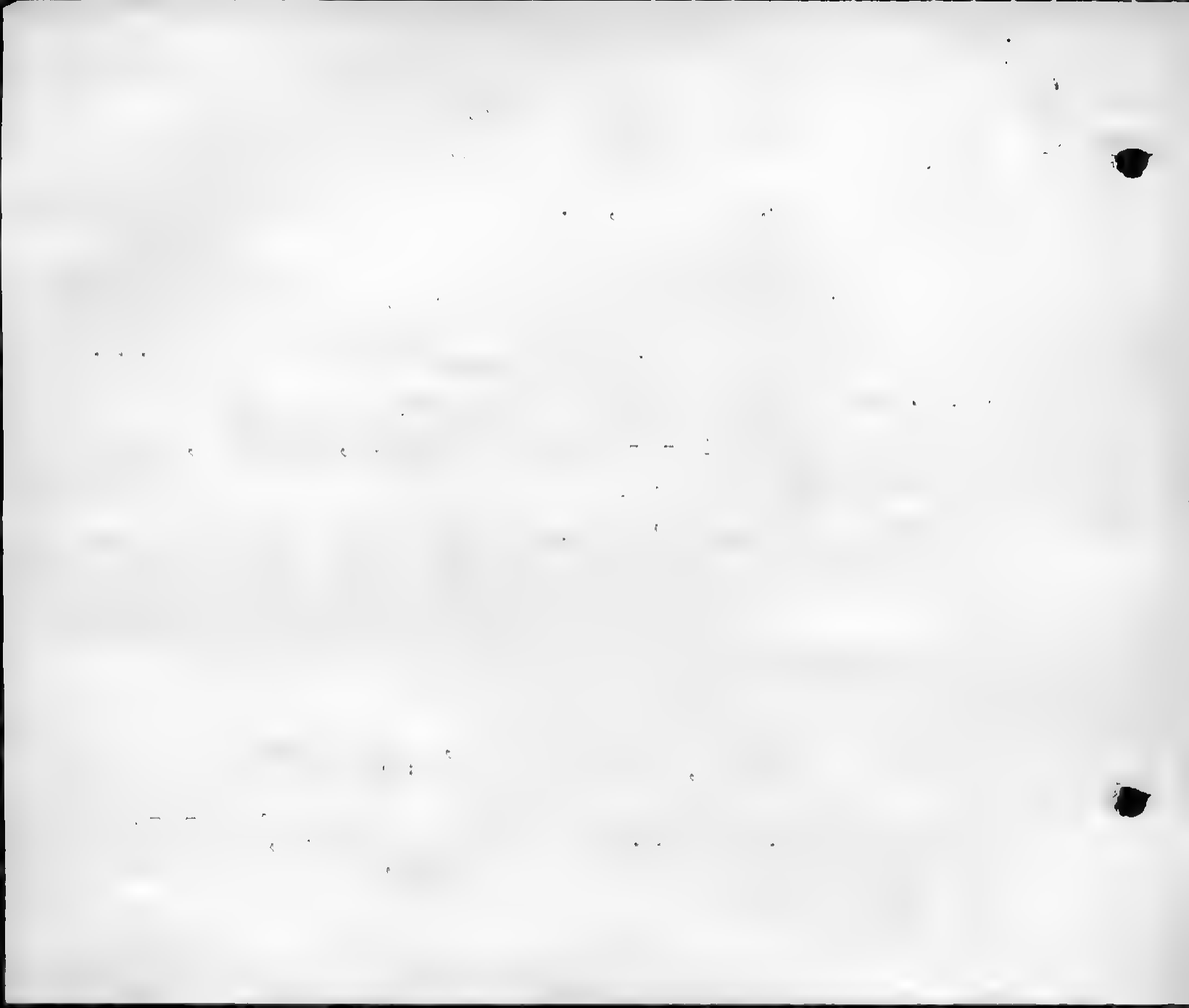


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
4410
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04411

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 44 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wisconsin b. COUNTY Superior e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Clay Middle Thomas Last Banks		4. DATE OF DEATH Month April Day 28 Year 1961	
5 SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 21, 1937	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months 23 Days 2 IF UNDER 24 HRS Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Banks		14. MOTHER'S MAIDEN NAME Lou Lucius	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 393-32-6623	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hodgkin's Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 Minutes 3 Years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from March 15, 1961 to April 28, 1961 , that (I) (we) last saw the deceased alive on April 28, 1961 , and that death occurred at 5:00AM from the causes and on the date stated above.			
22a. SIGNATURE Martin J. Cline M.D.		22b. DATE SIGNED 4-28-61	
22c. PHYSICIAN'S NAME (Type) Martin J. Cline M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-29-61		23b. DATE THEREOF 4-29-61	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City, town, or county) (State) Solon Springs, Wis.	
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY :		25a. REC'D BY REGISTRAR DATE MAY 3 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health; prior to burial, cremation, or removal, and in any event, within 72 hours after death.

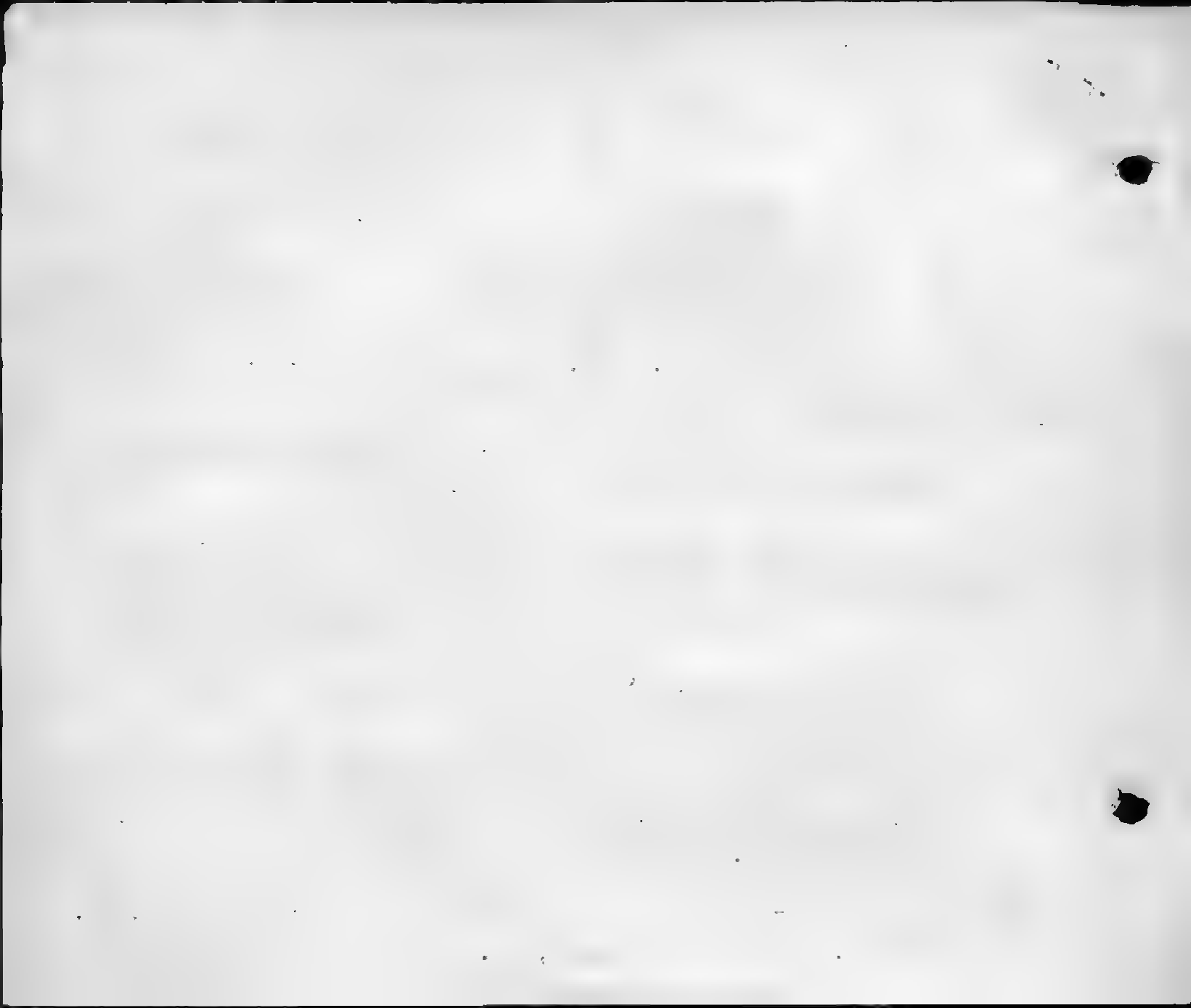
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health; prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2420

44412

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY (In days) 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 115 Forest Avenue		2. USUAL RESIDENCE (Where deceased lived, if instituted; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 115 Forest Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles A Beard		4. DATE OF DEATH April 17 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 9, 1882 79 yrs.	
9. AGE (In years, if under 1 year; if under 24 hrs., last birthday) 79 Months 17 Days 17 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk- Liberty Loan Treas. Dept.	
11. BIRTHPLACE (County & State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Henry Beard		14. MOTHER'S MARDEN NAME Martha Abbot	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO 214-28-4379A	
17. INFORMANT Harriet Ann Beard-Wife-Same Address 2d		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (b) years DUE TO (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 12, 1956 to April 17, 1961 that (I) (We) last saw the deceased alive on April 17, 1961 , and that death occurred at 4 AM , from the causes and on the date stated above.			
22a. SIGNATURE Stephen C. Cromwell		22b. DATE SIGNED 4-17-61	
22c. PHYSICIAN'S NAME (Type) STEPHEN C. CROMWELL		22d. ADDRESS 615 W. Montgomery Ave, Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-19-61	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town or county) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE APR 19 '61	



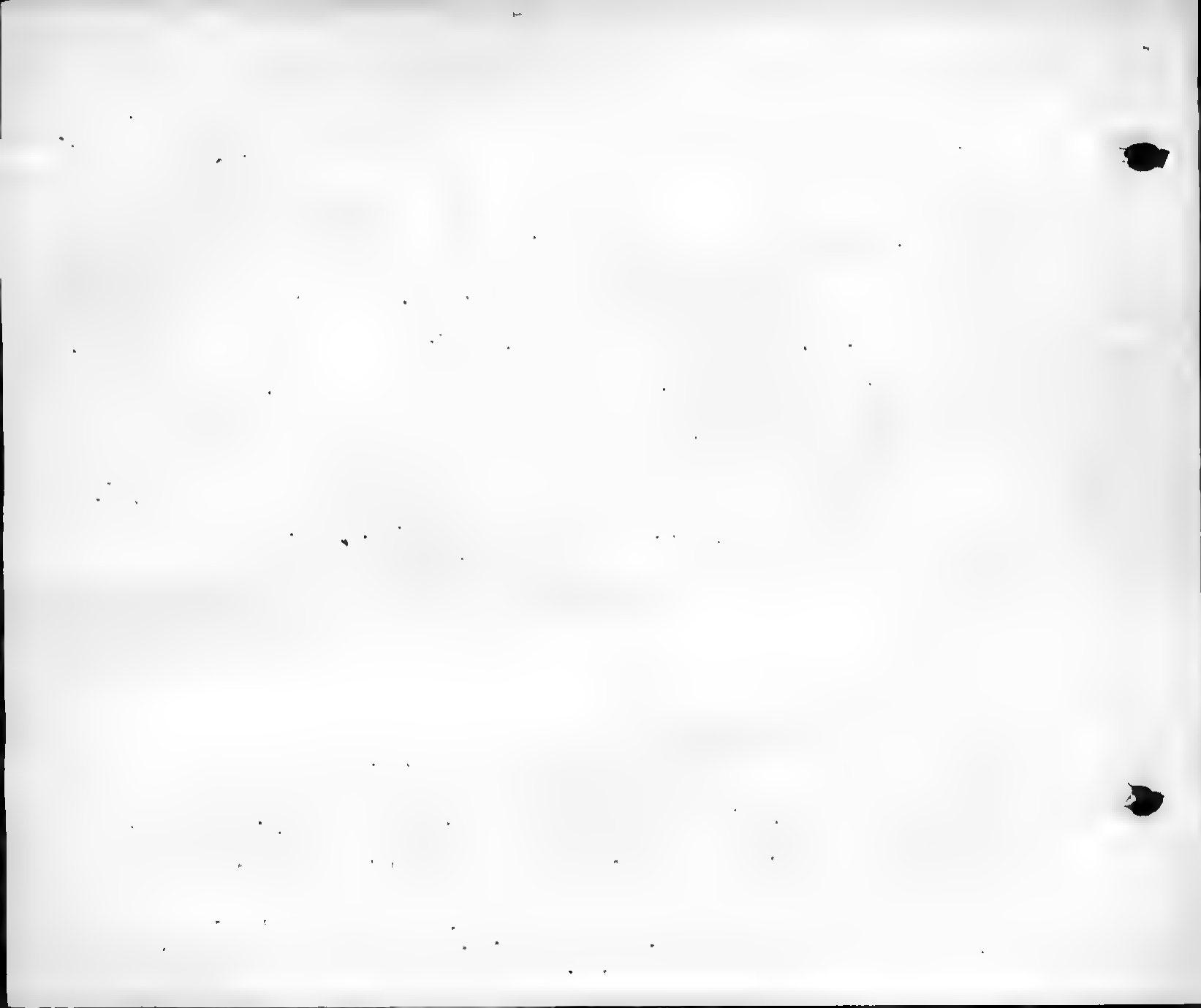
CERTIFICATE OF DEATH

Reg. Dist. No. 04413

4421

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Md.</u>		c. LENGTH OF STAY IN 1b <u>7 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jessie Mae Benson</u>		4. DATE OF DEATH <u>April 14 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1978</u>
9. AGE (In years lost birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jessie Lovell</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hodges</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go on, unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Beach</u>		Address <u>104 Beach Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 171X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Carcinoma of Cervix</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19 _____		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 29, 1960</u> to <u>April 14, 1961</u> , that I last saw the deceased alive on <u>April 14, 1961</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Corinne Cooper</u>		ADDRESS (Street, city or town, state) <u>104 S. Washington St. Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Neelsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		24a. REC'D BY REGISTRAR <u>1331 E. Montgomery Ave. Rockville, Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>		DATE <u>APR 18 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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4422

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04414

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>KENSINGTON GARDENS SAN.</i>		e. STREET ADDRESS <i>5825 Zikstone Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Isidore</i> Middle <i>-</i> Last <i>Bornstein</i>		4. DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 10, 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>GLOVE CUTTER -</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Mayer Bornstein (Dec)</i>		14. MOTHER'S MAIDEN NAME <i>Matilda Engelman (Dec)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>066-01-7473</i>	
17. INFORMANT <i>HARRY BORNSTEIN</i>		Address <i>BETH. MD 7825 FOLKSTONE RD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery disease</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of bladder.</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 years.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> 1960 to <i>Apr 28</i> 1961, that (I) (we) last saw the deceased alive on <i>Apr 28</i> 1961, and that death occurred at <i>10:25 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <i>Apr 28, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>OLAINE H. EIG, M.D.</i>		22d. ADDRESS <i>8041 Cleveland Rd Silver Spring Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4/30/1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR PARK Cem</i>		23d. LOCATION (City, town, or county) (State) <i>PARAMUS, N.J.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		25a. REC'D BY REGISTRAR <i>[Signature]</i>	
ADDRESS <i>Goetzberg Funeral Home 4217-9th Ave</i>		25b. REGISTRAR'S SIGNATURE <i>Charles E. Kneass</i>	
DATE <i>MAY 1 '61</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

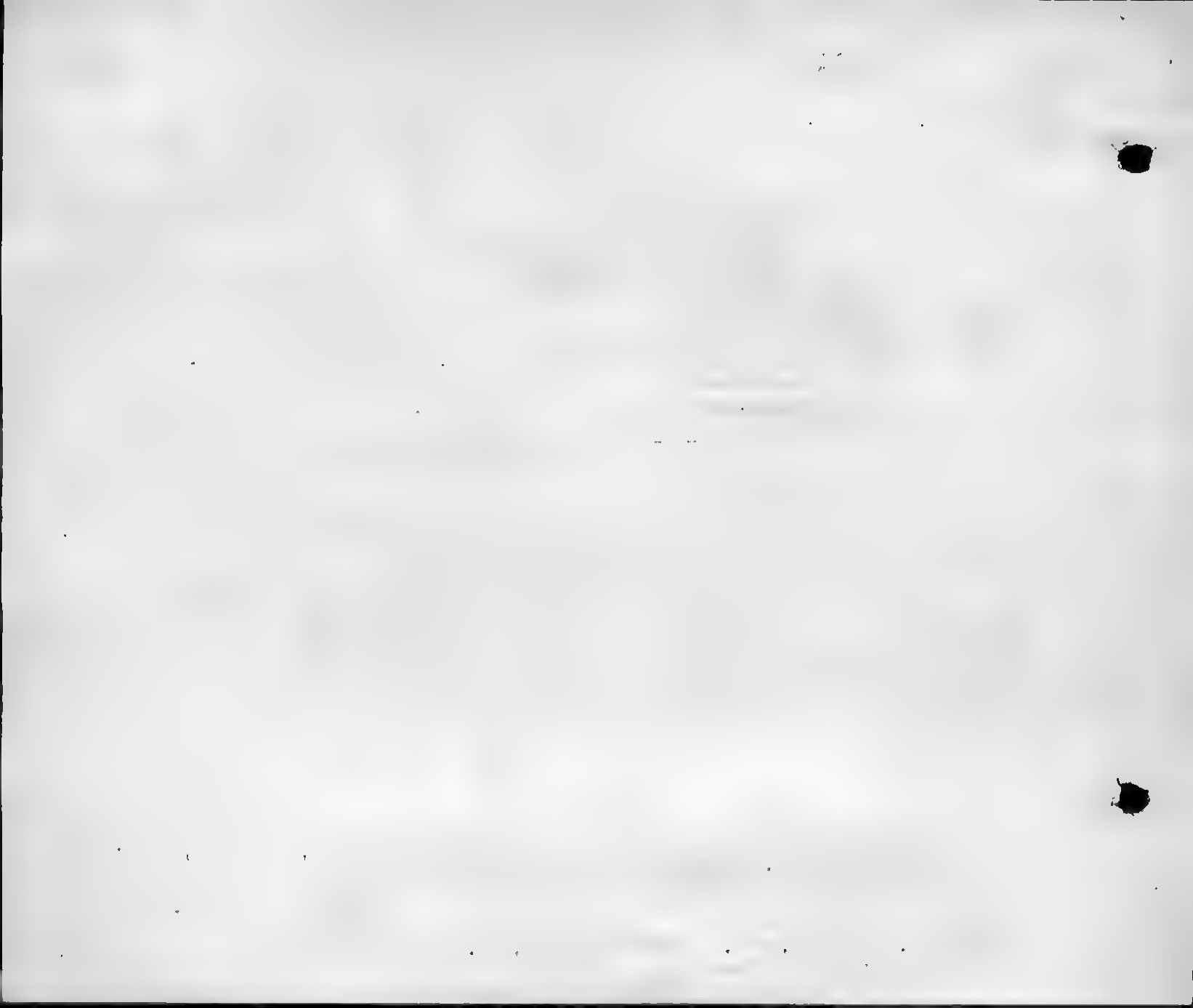
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4423

04415

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John, Bethesda</u> d. STREET ADDRESS <u>111 Mc Kay Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Justinus Carolus Nicolaas Bosdriesz</u> 4. DATE OF DEATH <u>April 10 1961</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/6/06</u> 9. AGE (in years if UNDER 1 YEAR; if UNDER 24 HRS. last birthday) <u>54</u> yrs Months <u>10</u> Days <u>19</u> Hours <u>61</u> Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Woodward & Lothrop</u> 11. BIRTHPLACE (Country & State or foreign country) <u>Amsterdam</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A Since 1960</u>			
13. FATHER'S NAME <u>Justinus Bosdriesz</u> 14. MOTHER'S MAIDEN NAME <u>Anna Voorveld Bosdriesz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO <u>527-42-1045</u> 17. INFORMANT <u>Wife Kornelia Bosdriesz (Same as Above)</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>Obstruction of small intestine due to tumor</u> (b) DUE TO <u>Adenocarcinoma of kidney with widespread metastases</u> (c) DUE TO <u>6 months</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> 20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.) <u>6719 Wilson Lane, Bethesda, Maryland</u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> to <u>4/10/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1961</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen W. Deijter</u> 22b. DATE SIGNED <u>4/10/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Stephen W. Deijter</u> 22d. ADDRESS <u>6719 Wilson Lane, Bethesda, Maryland</u> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>4/12/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u> 25a. REC'D BY REGISTRAR <u>APR 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04416

4424

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Somerset</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Somerset</u> 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4717 Falstone Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE L. BRADLEY</u>		4. DATE OF DEATH <u>APRIL 13 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/84</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nebraska</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Lebert</u>		14. MOTHER'S MAIDEN NAME <u>Lovina Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Mrs. John C. Lang</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL DEGENERATION</u> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>CHR LYMPHOCYTIC LEUKEMIA</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 WK+</u> <u>1 YR+</u> <u>7 YR</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEP 1960</u> to <u>15 APR 1961</u> , that I last saw the deceased alive on <u>APR 12 1961</u> , and that death occurred at <u>1:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1635 HARVARD ST</u>			
ACTUAL SIGNATURE <u>Myra B. Baker</u>		M.D. <u>1635 HARVARD ST</u>	
PHYSICIAN'S NAME (Type) <u>WYRTH POST BAKER, WASH. 9 DC.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4/15/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines C.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 14 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

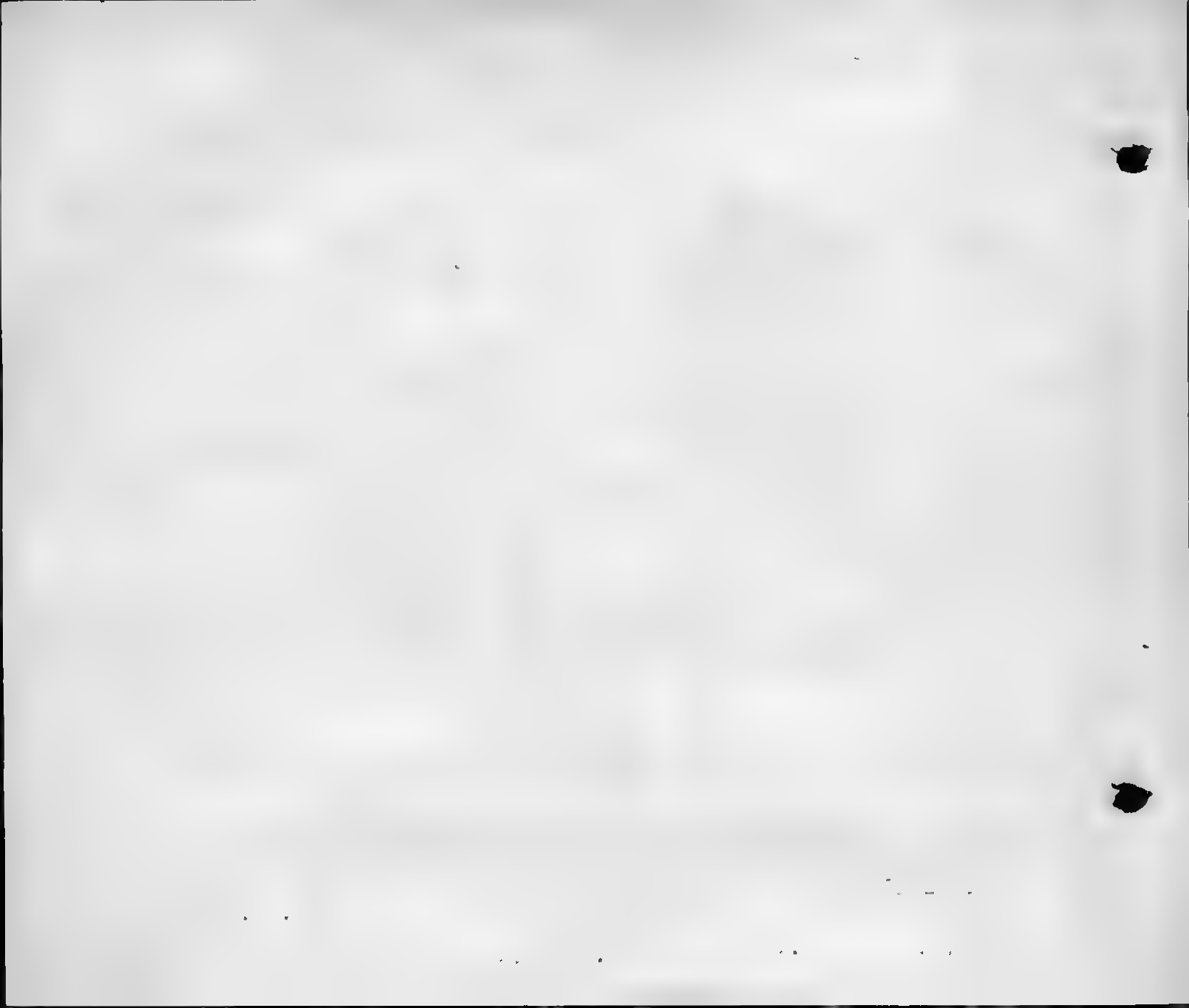
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04417

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Sumner Hills 9 ms.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Sumner Hills</u>	
c. LENGTH OF STAY IN TB <u>9 ms.</u>		d. STREET ADDRESS <u>5052 Westpath Ter</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Warren Spencer Brenizer</u>		4. DATE OF DEATH <u>Apr 14 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>excavation</u>	9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Warren F. Brenizer</u>		14. MOTHER'S MAIDEN NAME <u>Maud Y. Thorne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>4-14-61</u>	
17. INFORMANT <u>Rosie Brenizer (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>History of previous heart attacks</u> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-14-61</u>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL TO STATE <u>burial</u>	22b. DATE THEREOF <u>4/17/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or country) (State) <u>Pr. Geo. Co., Maryland</u>
23. FUNERAL DIRECTOR <u>The S.H.Hines Co., 2901 14th St. N.W., Wash, DC</u>		24a. REC'D BY REGISTRAR <u>APR 17 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION



TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4426
CERTIFICATE OF DEATH
04418

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN <u>Bethesda</u> c. LENGTH OF STAY <u>15</u> days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN <u>Washington</u> d. STREET ADDRESS <u>5442 Broad Branch Road</u>	
3. NAME OF DECEASED (Type or print) <u>Charles V Broadley</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/14/1902</u> 9. AGE (In years last birthday) <u>58</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Gov't</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>	
13. FATHER'S NAME <u>John Broadley</u>		14. MOTHER'S MAIDEN NAME <u>Harriet White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>yes</u> (If yes give war or date of service) <u>(Army) 059-104722</u>		17. INFORMANT <u>Margaret Broadley</u> Address <u>Same as Item 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>584X</u> DUE TO <u>Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Circulatory Collapse</u> <u>Acute Hemorrhagic Pancreatitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>30 hrs.</u> <u>looks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis & Cholecystectomy 4/12/61</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1946</u> to <u>4/21, 1961</u> , that (I) (we) last saw the deceased alive on <u>4/20 1961</u> , and that death occurred <u>3:22 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank J. Jagger Jr.</u> M.D.		22b. DATE SIGNED <u>4/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank J. Jagger Jr.</u>		22d. ADDRESS <u>5707 Wisconsin Ave Chevy Chase 15, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

11M

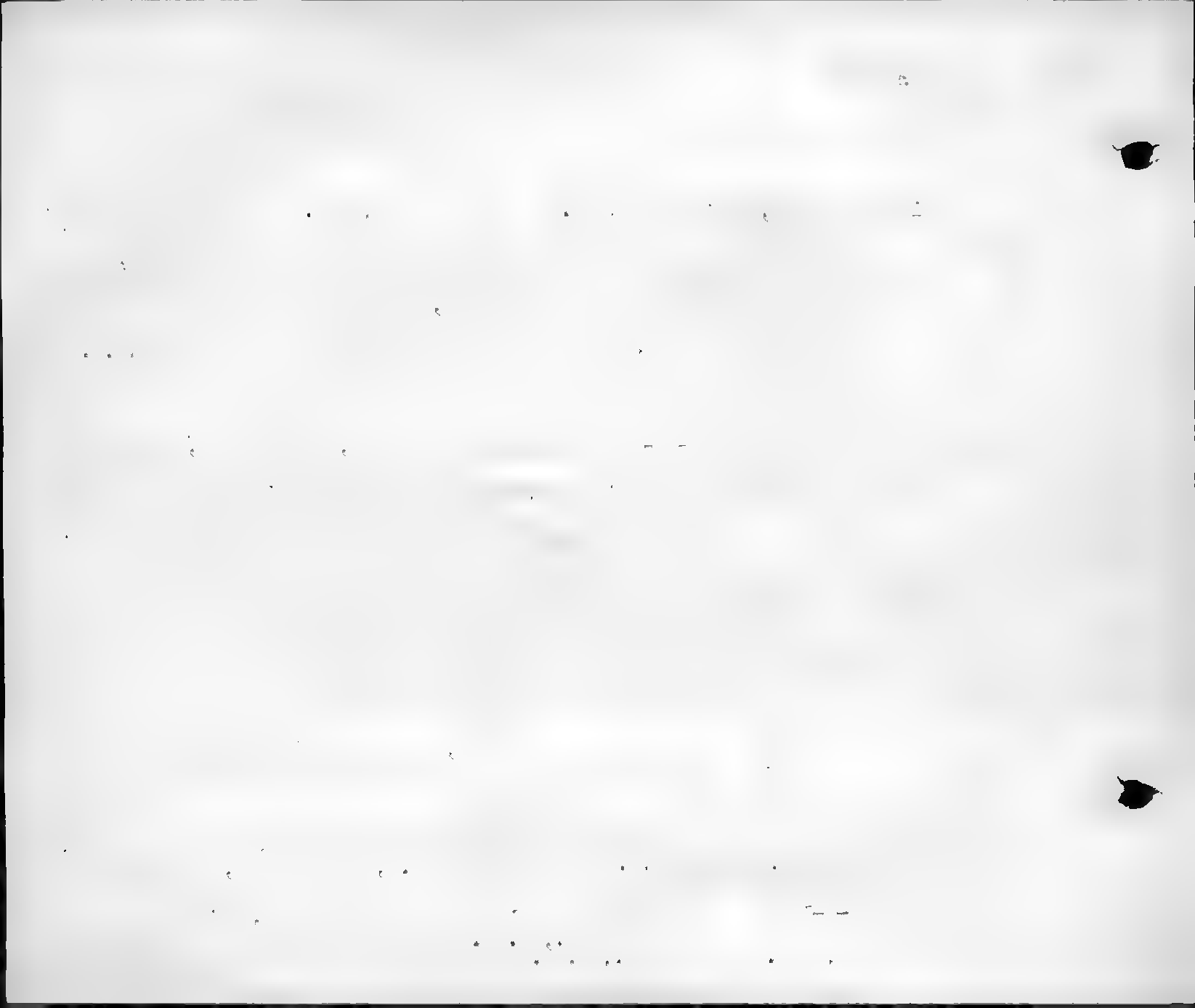
may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04419

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 619 C Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roxie Middle (None) Last Broadnax		4. DATE OF DEATH Month April Day 30 Year 1961	
5 SEX Female	6. COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1910
9 AGE (In years lost birthday) 51 yrs		10. IF UNDER 1 YEAR Months 51 Days 17 Hours 17 Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Willie Carter		14. MOTHER'S MAIDEN NAME Missouri Walker	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 230-16-3130	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ovarian Carcinoma Metastatic to the Brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Ovary DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 18 months	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from April 28, 1961 to April 30, 1961 , that (I) (we) lost saw the deceased alive on April 30, 1961 , and that death occurred on April 30, 1961 from the causes and on the date stated above.			
22a SIGNATURE Donald L. Morton		22b. DATE SIGNED 5/2/61	
22c. PHYSICIAN'S NAME (Type) DONALD L. MORTON, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 5-8-1961	
23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d LOCATION (City, town, or county) (State) Huntsville, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE MALVAN & SCHEY, INC.		25a. REC'D BY REGISTRAR Wash., D. C. 424 "R" St., N. W.	
25b REGISTRAR'S SIGNATURE Arthur S. Howard		25c. DATE MAY 8 '61	

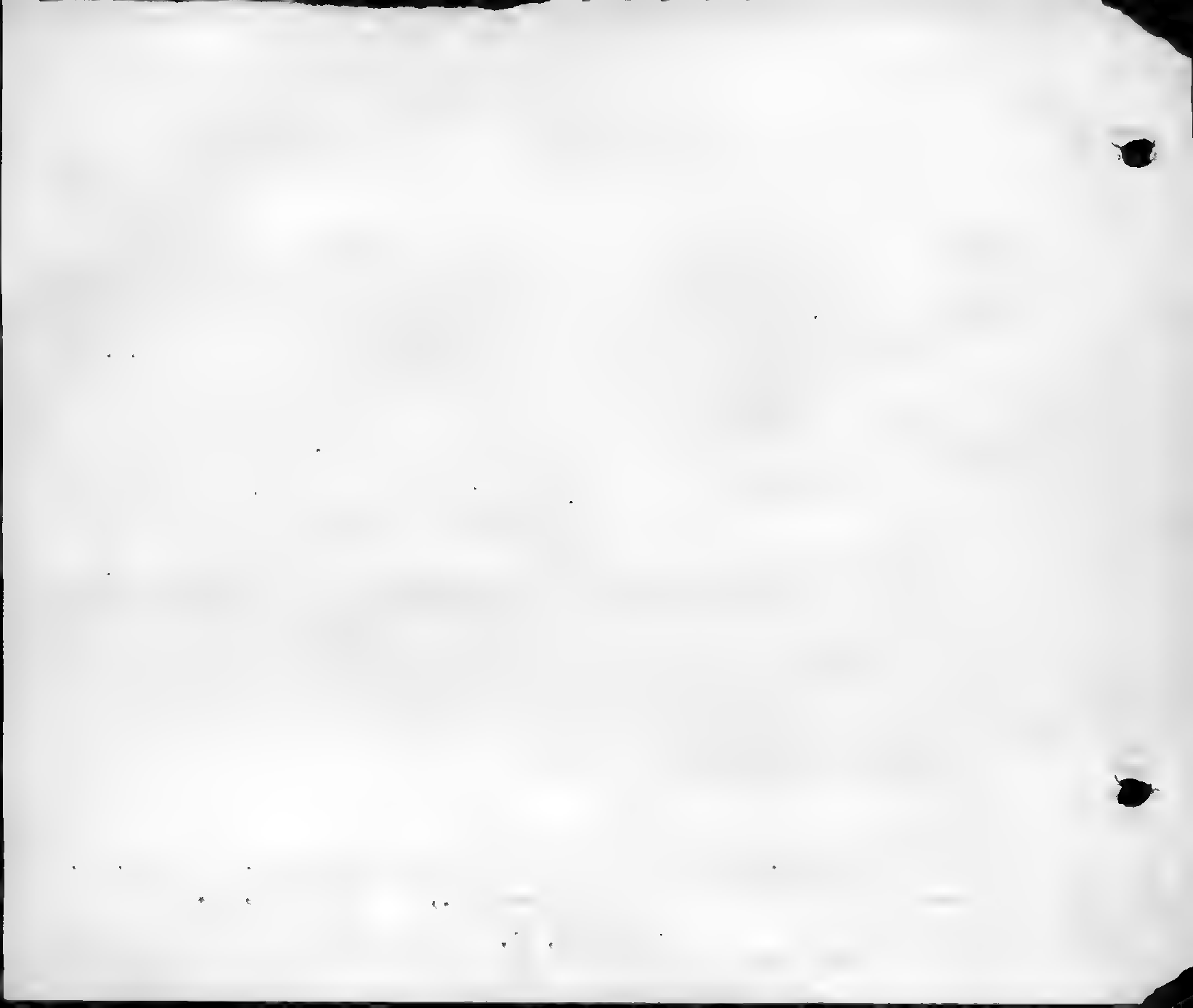


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04420

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Suburban				d. STREET ADDRESS Route # 2			
3. NAME OF DECEASED (Type or print) First Eliza Jane Middle Brown Last Brown				4. DATE OF DEATH Month April Day 24 Year 1961			
5. SEX Female		6. COLOR OR RACE col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/7/16	
9. AGE (In years last birthday) 44 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Ulysses Henry		14. MOTHER'S MAIDEN NAME Della			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-30-4950		17. INFORMANT Husband (Carlton Wm. Brown)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastro-intestinal bleeding, recurrent							
5810 DUE TO (b) Esophageal varices							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause (c) Cirrhosis of Liver							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 12 hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 22 March 1961 to 24 April 1961 , that (I) (we) last saw the deceased alive on 23 April 1961 , and that death occurred at 204 M, from the causes and on the date stated above							
22a. SIGNATURE [Signature]				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Richard C. Myers				22d. ADDRESS 8512 Old Georgetown Rd., Bethesda, Md.			
23a. BURIAL, CREMATION REMAINS Burial		23b. DATE THEREOF 4/28/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National.		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				25a. REC'D BY REGISTRAR DATE APR 28 '61		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

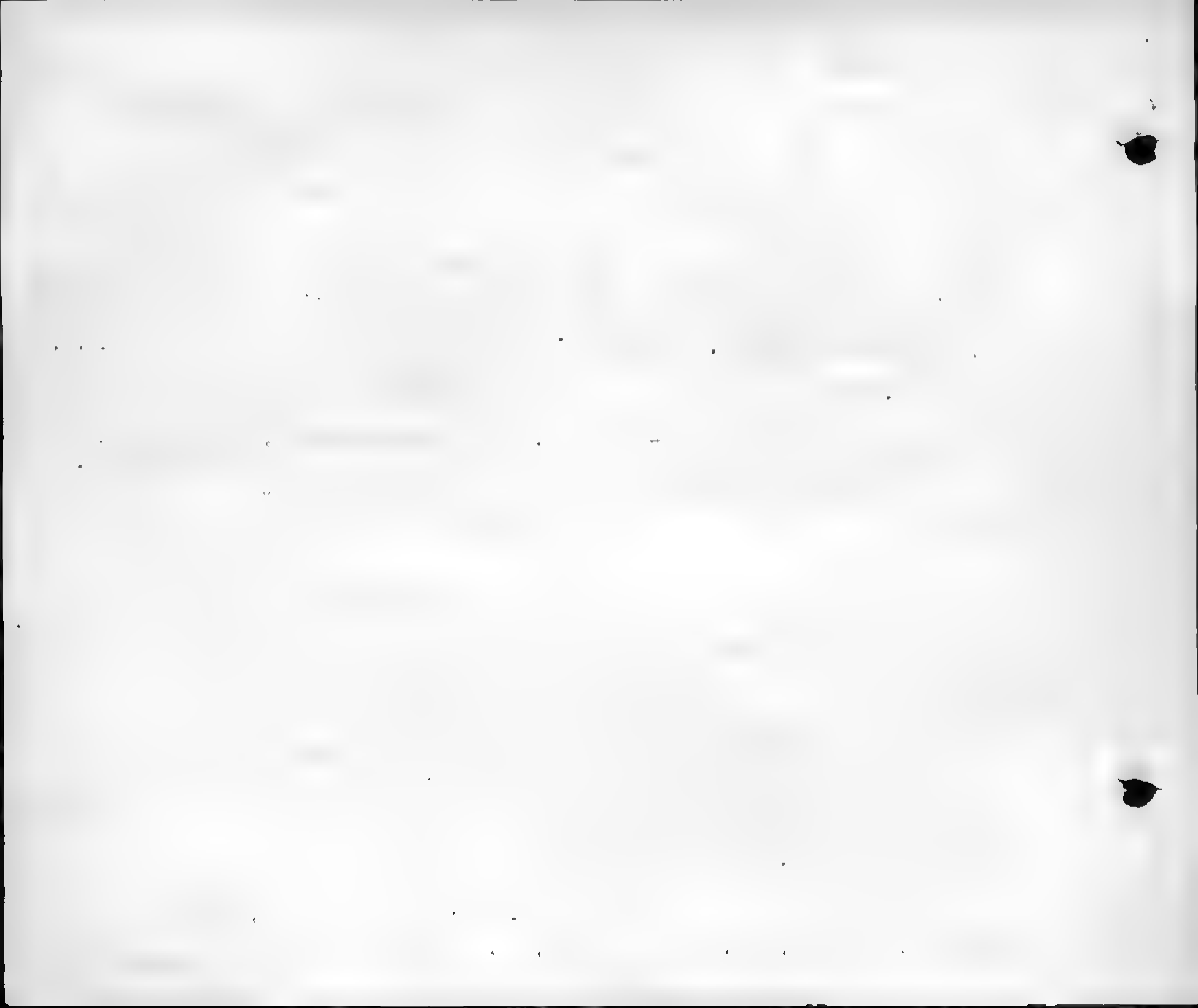
Reg. Dist. No. 04421

4429

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 SUNNYSIDE ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BETTY Middle WILSON Last BUCHANAN				4. DATE OF DEATH Month APRIL Day 14 Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/11/93	
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 12 Days 15 Hours 12 Min.		11. BIRTHPLACE (State or foreign country) NEW YORK STATE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer (retired) Art Dept. Retail Dept. Stores				10b. KIND OF BUSINESS OR INDUSTRY NEW YORK STATE			
13. FATHER'S NAME CHARLES L. WILSON				14. MOTHER'S MAIDEN NAME ANNA MANTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 213-10-5178			
17. INFORMANT Mr. John Raymond Buchanan, 109 Sunnyside Road Silver Spring, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Ovary DUE TO metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1956 to 14 April, 1961 that I last saw the deceased alive on 13 April, 1961 , and that death occurred at 2:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9016 Leesville Rd. Silver Spring, Md. DATE SIGNED 4/14/61 ACTUAL SIGNATURE William D. Aud M.D. William D. Aud PHYSICIAN'S NAME (Type) WILLIAM D. AUD							
22a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 4/18/61							
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY							
22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA							
23. FUNERAL DIRECTOR'S SIGNATURE WANNER E. PUMPHREY, INC. SILVER SPRING, MD.							
24a. REC'D BY REGISTRAR DATE APR 19 61							
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5.

may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
4430									
04422									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>				
c. LENGTH OF STAY IN 1b <u>1 mo</u>					d. STREET ADDRESS <u></u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u></u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Williams Fitzhugh Burgess</u>					4. DATE OF DEATH <u>Apr 16 1961</u>				
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>1-10-86</u>				
9. AGE (In years last birthday) <u>75</u> yrs.					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Mins.					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>dry cleaning</u>				
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Wm H Burgess</u>					14. MOTHER'S MAIDEN NAME <u>Willie Ann Bryan</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>577-05-4804</u>				
17. INFORMANT <u>Mary Burgess (wife)</u>					Address <u>Itan 2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					INTERVAL BETWEEN ONSET AND DEATH <u>found dead in bed</u>				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>+20.1</u>					(b) <u></u>				
(c) <u></u>									
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a) <u>Bronchial Asthma - years</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>					20f. (City or town) (County) (State) <u></u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Blaschke</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. Blaschke</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <u>4-16-61</u>				
					Address (Street, city, town, or country) <u></u>				
22a. BURIAL, CREMATION, or other disposition <u>Burial</u>					22b. DATE THEREOF <u>4-19-61</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>					22d. LOCATION (City, town, or country) (State) <u>Wash. D.C.</u>				
23. FUNERAL DIRECTOR <u>Robert A Mattingly</u>					24a. REC'D BY REGISTRAR <u>131-115882</u>				
					24b. REGISTRAR'S SIGNATURE <u>Robert A Mattingly</u>				
					DATE <u>APR 18 '61</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4431

04423

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY (In days) 88 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Florida b. COUNTY Jacksonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 334 E. Monroe Street d. STREET ADDRESS 40 x	
3. NAME OF DECEASED (Type or print) Peggy First BURKE Middle April 27 Last 1961 Year		4. DATE OF DEATH Month April 27 Day 1961 Year	
5. SEX Female 6. COLOR OR RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6-27-30 9. AGE (In years last birthday) 30 yrs. If UNDER 1 YEAR: Months Days If UNDER 24 HRS.: Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress 10b. KIND OF BUSINESS OR INDUSTRY Restaurant 11. BIRTHPLACE (County & State, or foreign country) Canada 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown JAMES		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 267-66-9057 17. INFORMANT (H) Thomas B. Burke, IC2, USN, USS SATATOGA, Address c/o FPO, New York	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Renal Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Squamous cell Carcinoma Cervix Uteri DUE TO (c) 3 mo 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 29, 1961 to April 27, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 27, 1961 , and that death occurred at 4:10 PM , from the causes and on the date stated above.			
22a. SIGNATURE R. F. Mading 22c. PHYSICIAN'S NAME (Type) R. F. MADING, LT, MC, USN		22b. DATE SIGNED 4-28-61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-2-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Whelan 24b. ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE MAY 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

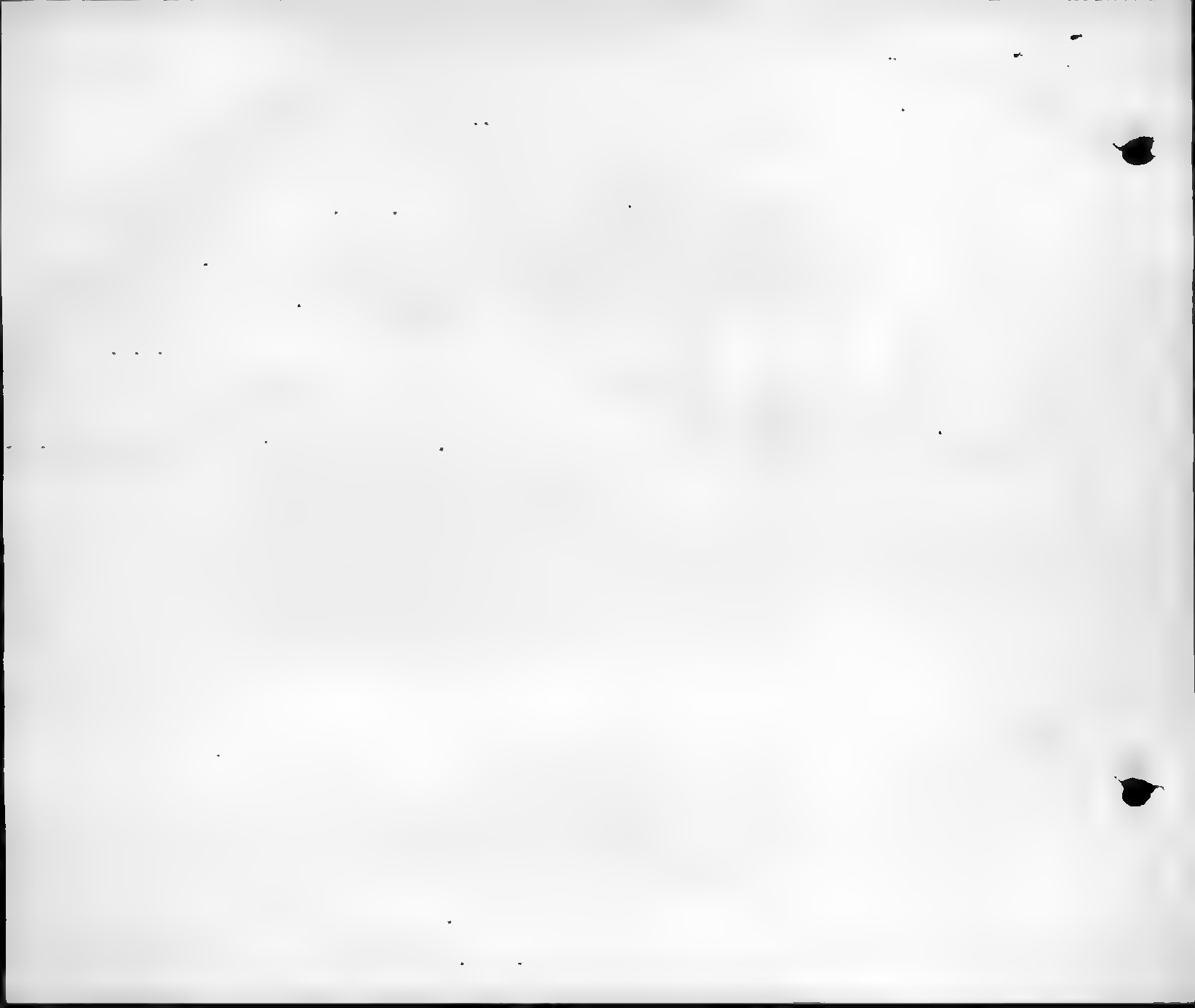


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4432

04424

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. LENGTH OF STAY IN Ib <i>Colmar Manor</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanatorium</i>				d. STREET ADDRESS <i>3408 42Nd. Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MOSBY</i> Middle <i>A.</i> Last <i>BUTT</i>				4. DATE OF DEATH Month <i>APRIL</i> Day <i>10</i> Year <i>1961</i>			
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11 MAY 1877</i>	
9. AGE (In years last birthday) <i>83</i> yrs		F UNDER 1 YEAR IF UNDER 24 HRS		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>JNO HENRY BUTT</i>				14. MOTHER'S MAIDEN NAME <i>IDA I. Ricketts</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dated service) <i>NO</i>				16. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT Address <i>Matilda E. Ricketts 10801 Hunting Lane, Rock, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> 4341 DUE TO (b) <i>Hydrothorax - right</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Chronic Anginous Heart Failure</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic progressive - feb - arteriosclerotic.</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>18 hrs</i> <i>2 mo.</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1960</i> to <i>Apr 10, 1961</i> , that (I) (we) last saw the deceased alive on <i>Mar 28 1961</i> , and that death occurred at <i>10:00 AM</i> from the causes and on the date stated above							
22a. SIGNATURE <i>Robert T. Thibadeau</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>Apr 10 - 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU</i>				22d. ADDRESS <i>KENSINGTON, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/13/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Potomac Church Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Potomac, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i>				25a. REC'D BY REGISTRAR <i>APR 13 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kross</i>	
25c. ADDRESS <i>1331 East Montgomery Ave. Rock, Md.</i>							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

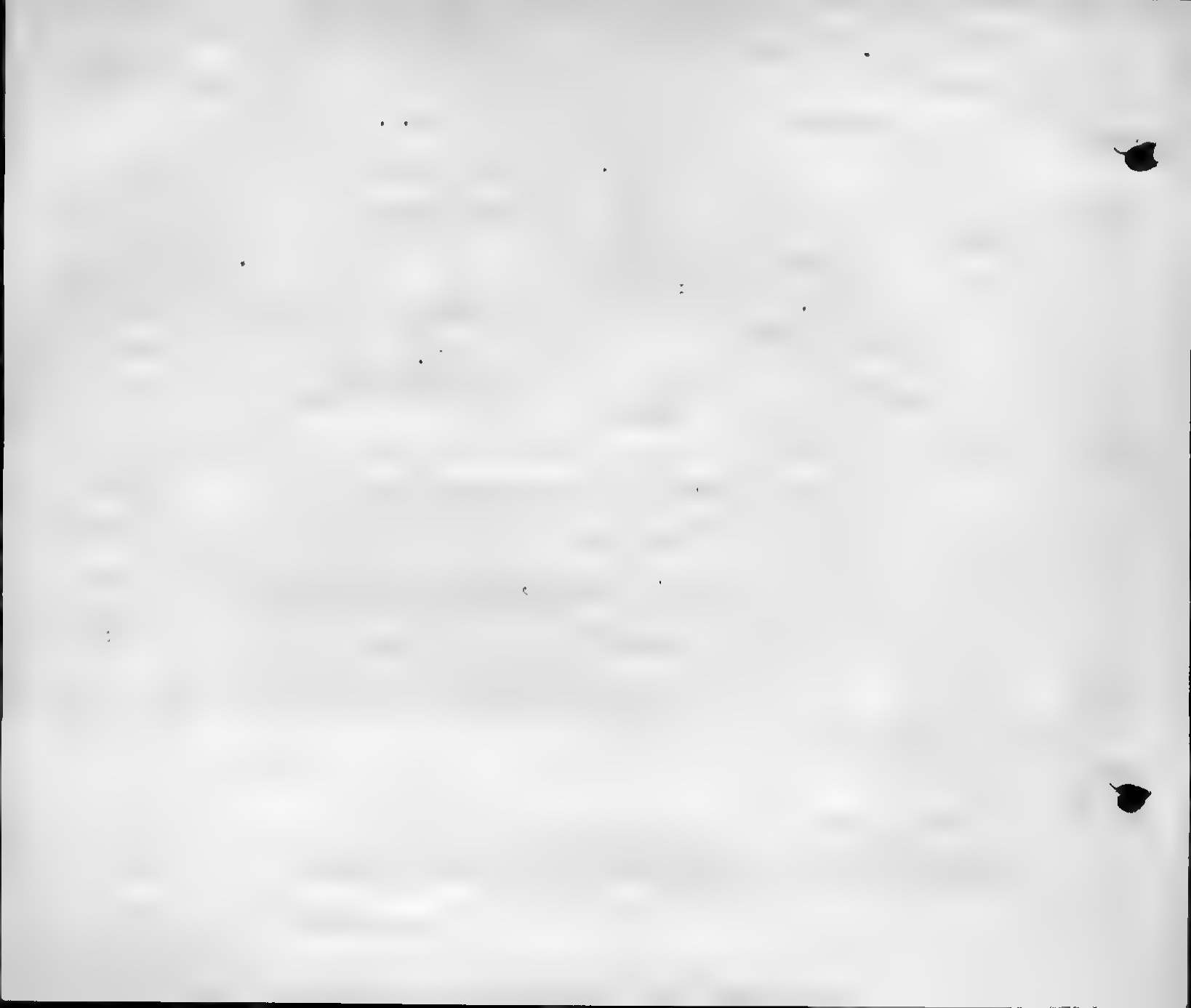
VS. A15ME
5M 7/59

4433

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04425

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Carroll		4. DATE OF DEATH Month Apr. Day 27 Year 1961	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 42 yrs.
11. BIRTHPLACE (State or foreign country) Mad.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Carroll		14. MOTHER'S MAIDEN NAME Dottie Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Herniation of brain stem DUE TO Cerebral edema Conditions, if any, which gave rise to immediate cause (b) Ruptured aneurysm, Anterior communicating artery caused last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
INTERVAL BETWEEN ONSET AND DEATH Sudden 6 hours 6 hours			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		M.D.	
EXAMINER'S NAME (Type) FRANK J. Broschert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2 May 1961	
22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Newberg, Maryland	
23. FUNERAL DIRECTOR Killie E. Amwood		ADDRESS 4609-14th St N.W.	
24a. REC'D BY REG. STRAR MAY 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

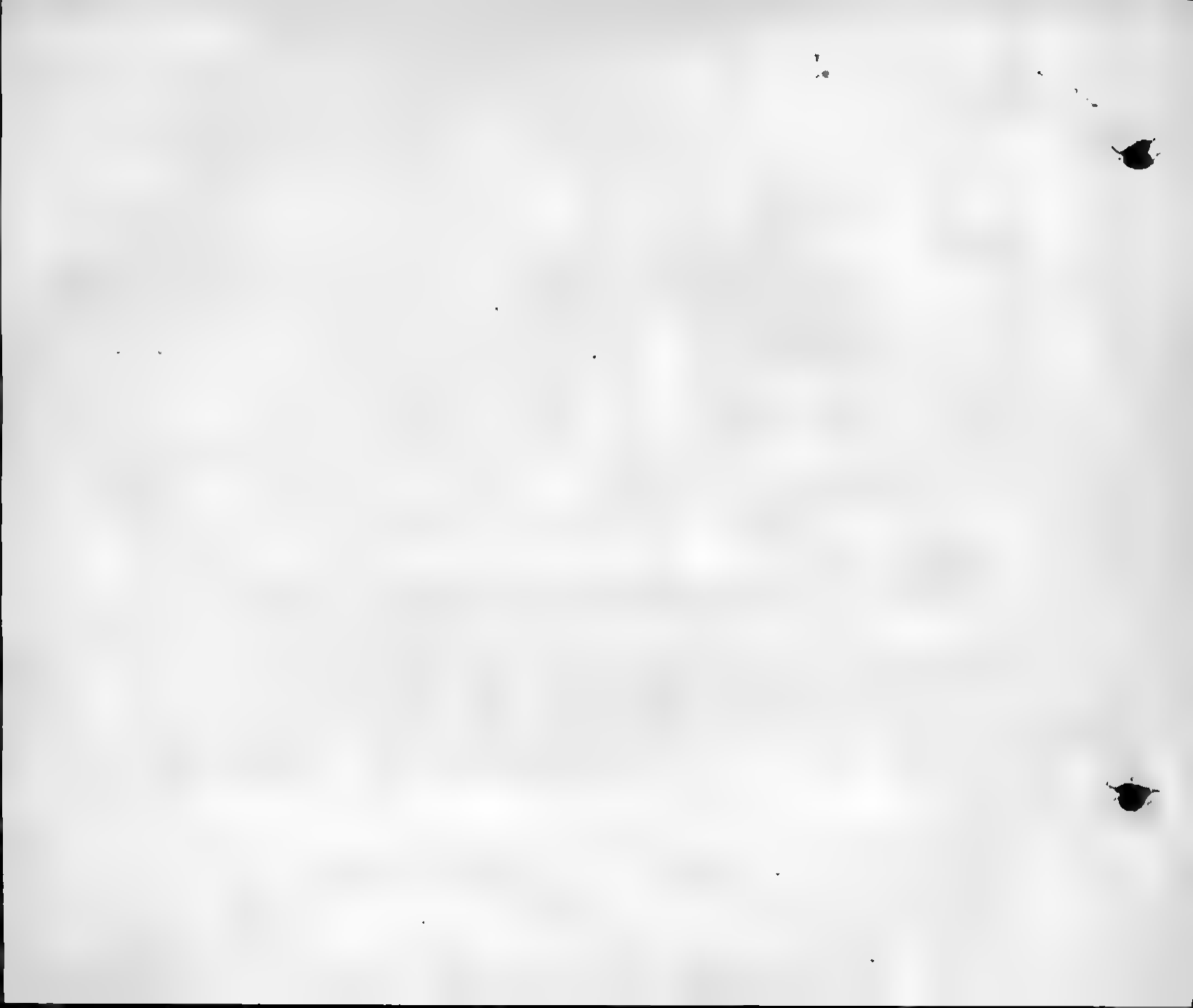
4434

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04426

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4721 Drummond Ave.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
f. STREET ADDRESS 4721 Drummond Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Bernard Last Carry				4. DATE OF DEATH Month April Day 5 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 13, 1889	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 13 Hours 13 Min. 13		IF UNDER 24 HRS. Hours 13 Min. 13			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chestnut Farms Dairy				10b. KIND OF BUSINESS OR INDUSTRY Retired.		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Luke Carry				14. MOTHER'S MAIDEN NAME Mary McNamee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes Unknown		17. INFORMANT Wife Mabel Carry		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 420.1 DUE TO (c) 420.1 INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/61		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR APR 10 61	
				24b. REGISTRAR'S SIGNATURE William S. Hana		DATE April 5, 1961	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

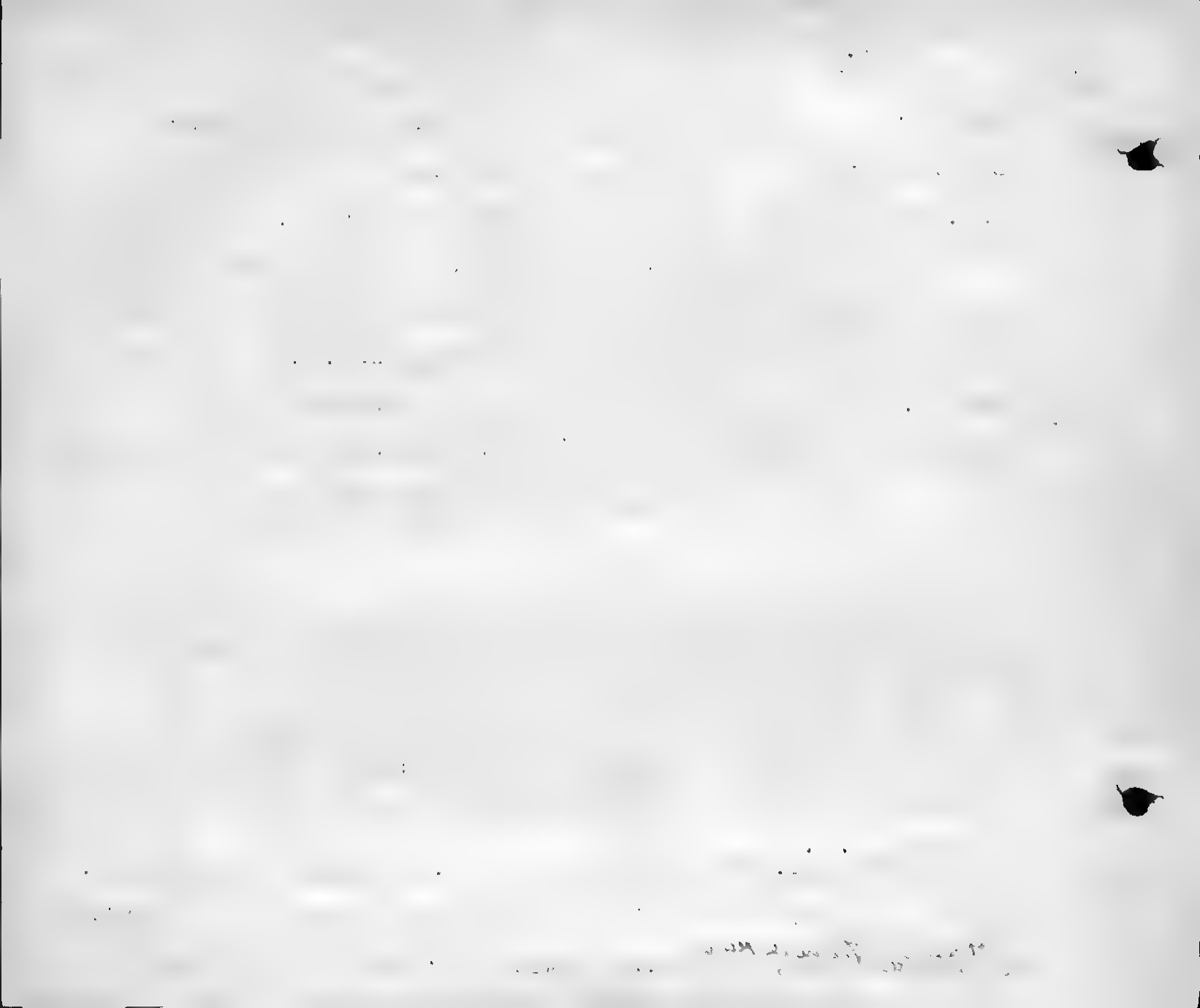
CERTIFICATE OF DEATH

4435

04427

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 4611 Montgomery Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas James		4. DATE OF DEATH April 26 19 61		f. DATE OF BIRTH 9-1-06	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		9. AGE (In years last birthday) 54 yrs.		10. BIRTHPLACE County & State, or foreign country Washington, D. C.	
11. FATHER'S NAME James K. CHACONAS		12. CITIZEN OF WHAT COUNTRY? USA		13. MOTHER'S MAIDEN NAME Virginia B. BOORAS	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1943 to 1945		15. SOCIAL SECURITY NO. (W) Mrs. Nancy H. Chaconas, same as #2 above		16. INFORMATION Address	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intercranial Hemorrhage Monocytic Leukemia		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20a. CITY OR TOWN		20b. COUNTY		20c. STATE	
21. I certify that (If in hospital) attended the deceased from April 15 1961 to April 26 1961 that (X) (we) last saw the deceased alive on April 26 1961 , and that death occurred at 6:02 PM , from the causes and on the date stated above.					
22a. SIGNATURE R. G. MUTH, LT, MC, USN		22b. DATE SIGNED 4-27-61		22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 May 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	
23d. LOCATION (City, town or county) Arlington		23e. STATE Virginia		23f. REC'D BY REGISTRAR DATE MAY 1 '61	
23g. REGISTRAR'S SIGNATURE Arthur S. Kiana		23h. REGISTRAR'S SIGNATURE Arthur S. Kiana			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 is retained by the hospital or attending physician. Page 5 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

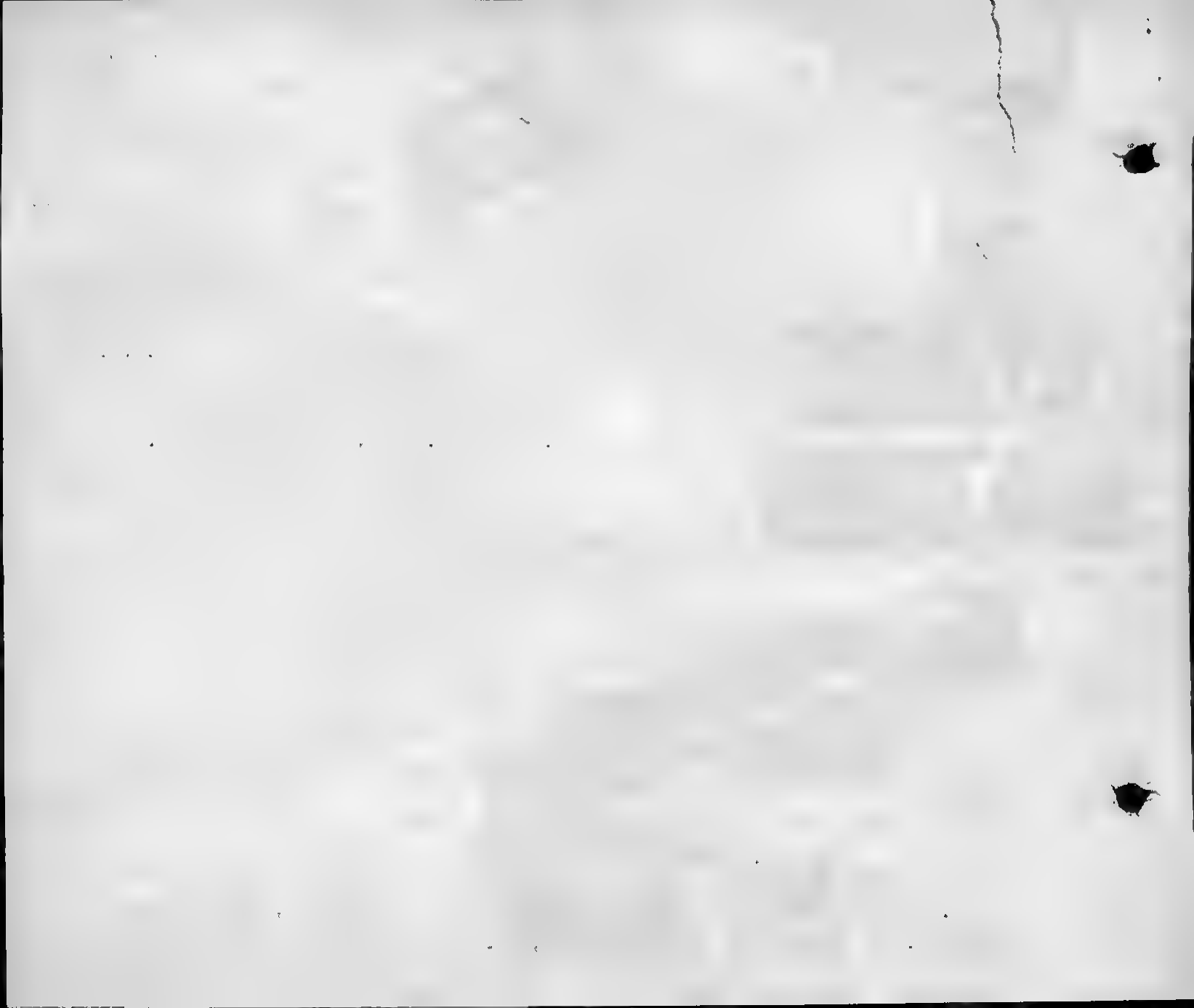
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4436

04428

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY in b. 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2666 Cory Terrace		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 2666 Cory Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADALINE FORD First Middle Last 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH CLARK Month Day Year 4 18 1961 8. AGE (in years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) CLARKSBURG, WEST VIRGINIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL FORD		14. MOTHER'S MAIDEN NAME CATHERINE KENNEDY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE 17. INFORMANT Mr. Martin L. Ford, 4007 Southend Rd. Rockville, Maryland Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Extreme tachypnea DUE TO (c) Carcinomatosis CONDITIONS, if any, which 90% rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Chronic bronchitis Emphysema Coronary atherosclerosis		19. INTERVAL BETWEEN ONSET AND DEATH 18-22 hr 18-22 hr 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month Day Year Hour e.m. p.m. 19 20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 1958 to April 1961 , that (I) (we) last saw the deceased alive on 4-17 1961 , and that death occurred at 4 PM , from the causes and on the date stated above.			
22a. SIGNATURE Richard P. Delaney 22c. PHYSICIAN'S NAME (Type) RICHARD P. DELANEY		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 4323 Howard St. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 23b. DATE THEREOF 4/22/61		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY 23d. LOCATION (City, town or county) (State) FAIRMONT, WEST VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Werner E. Pommeroy, Inc. Raymond A. Giska		25a. REC'D BY REGISTRAR APR 21 '61 25b. REGISTRAR'S SIGNATURE Arthur S. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G286 5/3/61 lwk

CERTIFICATE OF DEATH

Reg. Dist. No.

04423

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMORELAND HILLS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMORELAND HILLS, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4515-WETHERILL ROAD				d. STREET ADDRESS 4515-WETHERILL ROAD			
3. NAME OF DECEASED (Type or print) First GEORGE Middle C. Last CLARK				4. DATE OF DEATH Month APRIL Day 26 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1862	9. AGE (In years last birthday) yrs. 98	IF UNDER 1 YEAR: Months 6 Days 29 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY MEDICINE		11. BIRTHPLACE (State or foreign country) SCHELLSBURG, PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ALEXANDER BOYD CLARK				14. MOTHER'S MAIDEN NAME JANE LARUE RAMSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HELEN L. CLARK Address Westmoreland 4515 WETHERILL RD. Hills			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH SUDDEN 20 YRS. PLUS SIXTY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1937 , 1937 , to APRIL 26 , 1961 , that I last saw the deceased alive on APRIL 26 , 1961 , and that death occurred at 7:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1801-EYE STREET, N.W. DATE SIGNED 							
ACTUAL SIGNATURE Alan Frank Kreglow, M.D.							
PHYSICIAN'S NAME (Type) DR. ALAN FRANK KREGLOW, M.D. 1801 EYE STREET, N.W. - WASH. D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 1/61	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSO				24a. REC'D BY REGISTRAR DATE MAY 1 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

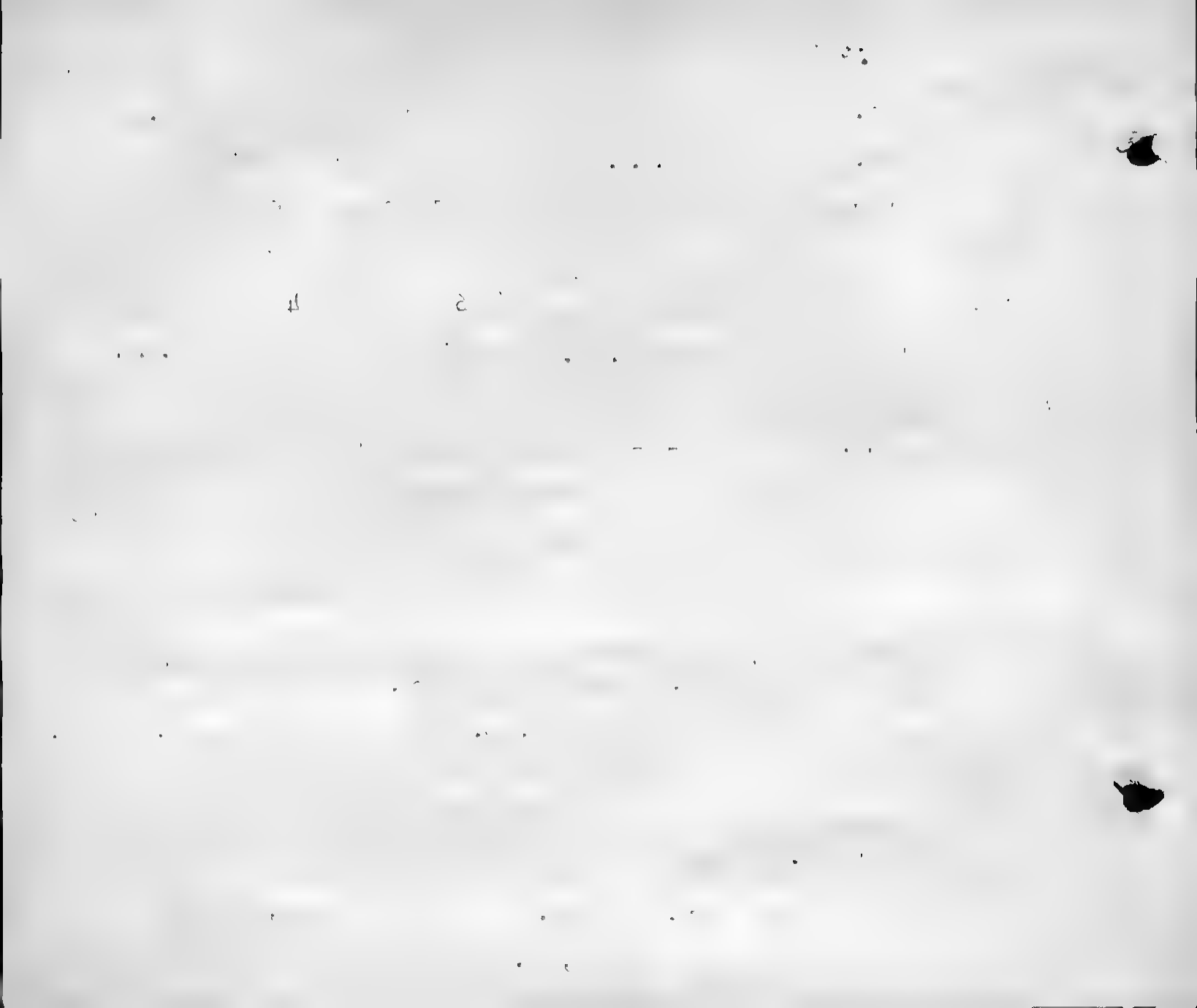
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04430

1. PLACE OF DEATH a. COUNTY Mont. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beth. c. LENGTH OF STAY, IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney Acres Rockville d. STREET ADDRESS 17712 Ridge Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Earl Compton		4. DATE OF DEATH Month 4 Day 17 Year 19 61			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/16	9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Roof Const. Co.		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Perry Compton		14. MOTHER'S MAIDEN NAME Missouri Gilbert		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2 577-32-3074		17. INFORMANT Robert Compton (brother) Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 1213 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH Found asleep in truck	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Truck was being heated by lead melting pot which burns charcoal. Found asleep in truck.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 4/17 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Const. Co. Plant	
		20f. (City or town) Rockville		(County) Mont. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank G. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/17/61	
EXAMINER'S NAME (Type) Frank G. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/61		22c. NAME OF CEMETERY OR CREMATORY Arl. Nat'l Cem.	
				22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR Francis H. Barker		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR APR 20 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No. 0443

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>3000 W. Conover Ave</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring,</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Keeney's Home</i>		d. STREET ADDRESS <i>109 North wood Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>FRANCIS</i> Middle <i>E</i> Last <i>CH. KESY</i>		4. DATE OF DEATH Month <i>June</i> Day <i>12</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 30, 1884</i>
9. AGE (In years last birthday) <i>75</i> yrs		IF UNDER 1 YEAR Months <i>7</i> Days <i>12</i> Hours <i>19</i> Min <i>61</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipping Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Continental Tire</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Francis Draven Cooksey</i>		14. MOTHER'S MAIDEN NAME <i>Alison Rice Chalmers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>June Knapp</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sudden Heart Failure</i>			
(b) <i>Sent to hospital 4-7-57</i>			
(c) <i>Under observation several</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/15/61</i> 19, to <i>4/12/61</i> 19, that I last saw the deceased alive on <i>4/12/61</i> 19, and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel Allen</i>		DATE SIGNED <i>4/12/61</i>	
PHYSICIAN'S NAME (Type) <i>Samuel Allen, M.D.</i>		Address <i>Kensington Maryland</i>	
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF <i>4-15-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Catholic</i>	22d. LOCATION (City, town, or county) (State) <i>South east MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. ...</i>		24a. REC'D BY REGISTRAR DATE <i>APR 14 '61</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles S. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



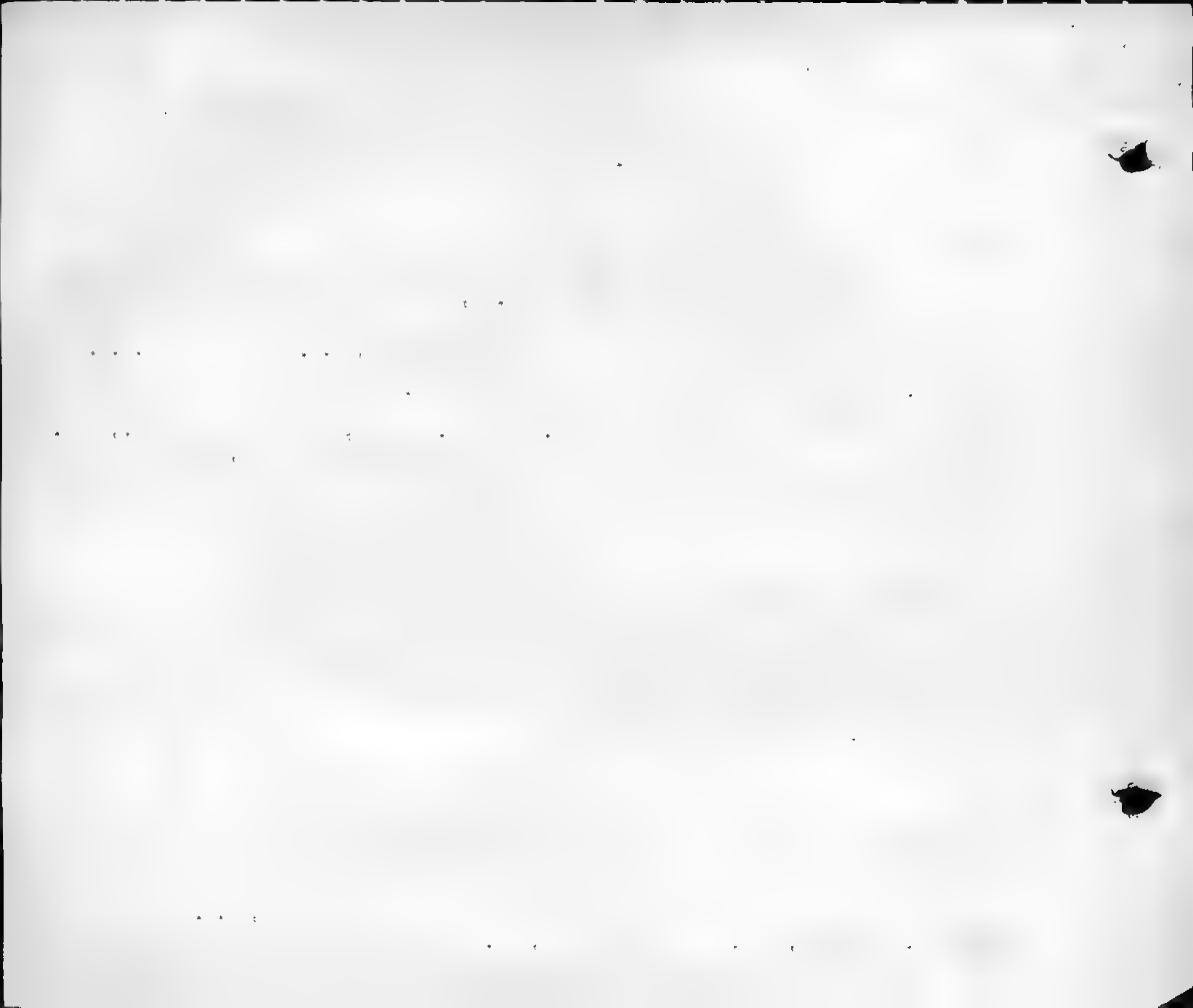
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained for hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

4440
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04432

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2101 HILDAROSE DRIVE		d. STREET ADDRESS 2101 HILDAROSE DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last ELLA MAE COOLEY		4 DATE OF DEATH Month Day Year APRIL 7 1961	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 6, 1876
9 AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11 BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GEORGE W. DONN		14 MOTHER'S MAIDEN NAME ELLEN M. COURTNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17 INFORMANT Mr. Harry D. Cooley, 2101 Hildarose Dr., Apt. 102 Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Hemorrhage</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>January 1960</u> to <u>April 1961</u> , that (I) (we) last saw the deceased alive on <u>April 6 1961</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert J. Lichman</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/10/61	
23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jiska</u>		25a. REC'D BY REGISTRAR DATE APR 11 '61	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. 04433

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> 34	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12012 VALLEYWOOD DRIVE</u>		d. STREET ADDRESS <u>12012 VALLEYWOOD DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>FRANCIS</u> Last <u>COURTNEY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3 1884</u> 77 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>BOSTON MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS WILLIE COURTNEY</u> Address <u>12012 Valleywood Dr Wheaton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> DUE TO (b) <u>Chronic Congestion</u> DUE TO (c) <u>HYPERTENSIVE Cardiovascular Disease</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>142X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Two Months</u> <u>5 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Lung Abscess, Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1955</u> to <u>April 10 1961</u> , that I last saw the deceased alive on <u>April 10 1961</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Crowell</u>		ADDRESS (Street, city or town, state) <u>2025 EYE Street N.W. Washington D.C.</u>	
PHYSICIAN'S NAME (Type) <u>JACK CROWELL</u>		DATE SIGNED <u>APR 12 '61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-13-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		ADDRESS <u>3072-M-SPR.W.</u>	
24a. REC'D BY REGISTRAR <u>APR 12 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

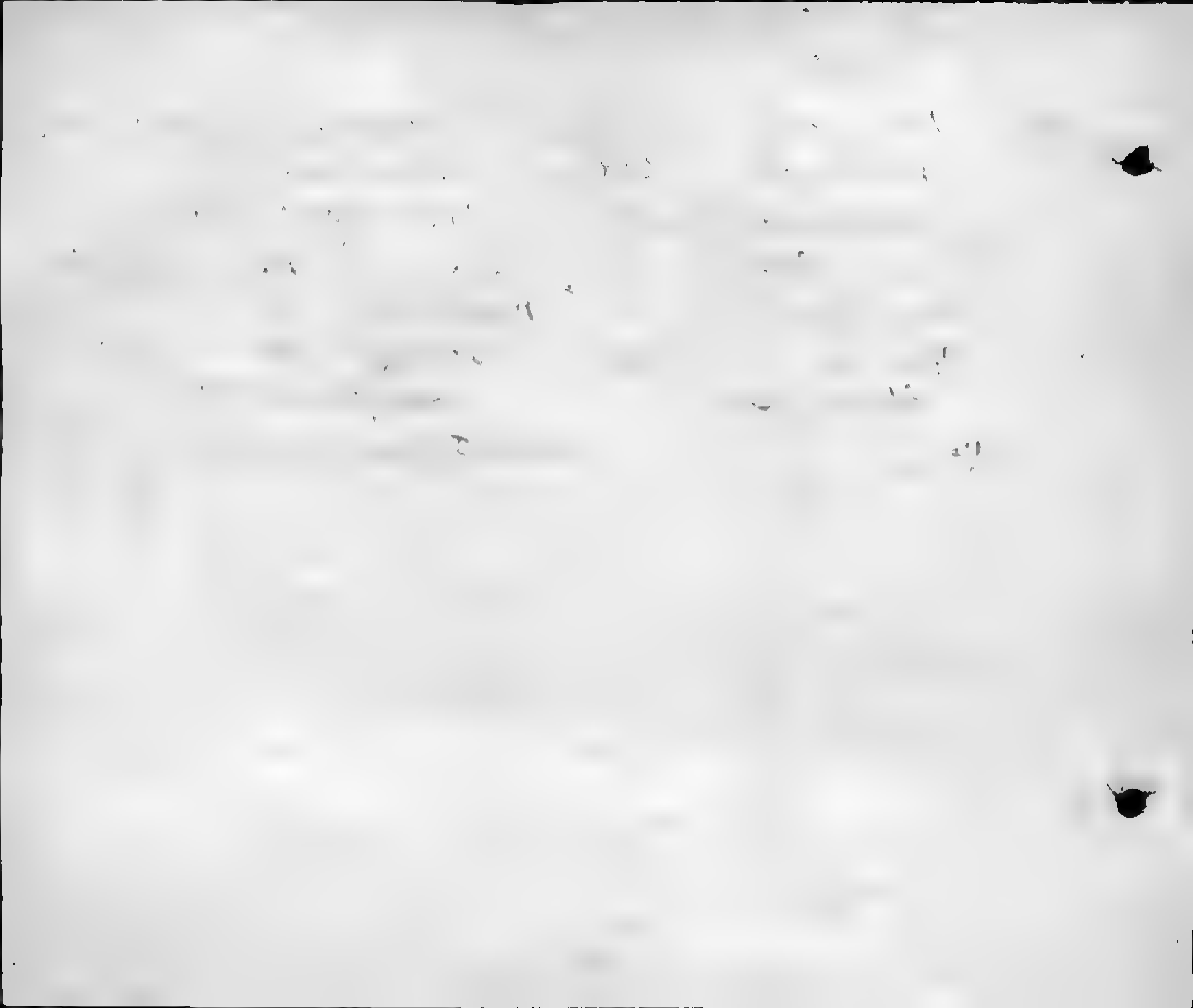
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4442

04434

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>24 days</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>59 Silver Spring</u> d. STREET ADDRESS <u>1903 August Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles R Cox</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1899</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lino type</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Cox</u>				14. MOTHER'S M maiden name <u>Desigiana Webster</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bertha I Cox (sister)</u> (same as above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO (b) <u>Rheumatic heart disease - aortic stenosis & insufficiency</u> (a), stating the underlying cause last. } DUE TO (c) <u>and Arteriosclerotic heart disease</u>								INTERVA. BETWEEN ONSET AND DEATH <u>4 months known</u> <u>10 years known</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from... 19... to <u>April 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1961</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Carson H. Trau</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 10, 1961</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>4-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 14 '61</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Desert Funeral Home</u>				25b. REGISTRAR'S SIGNATURE <u>William S. Fenn</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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4443

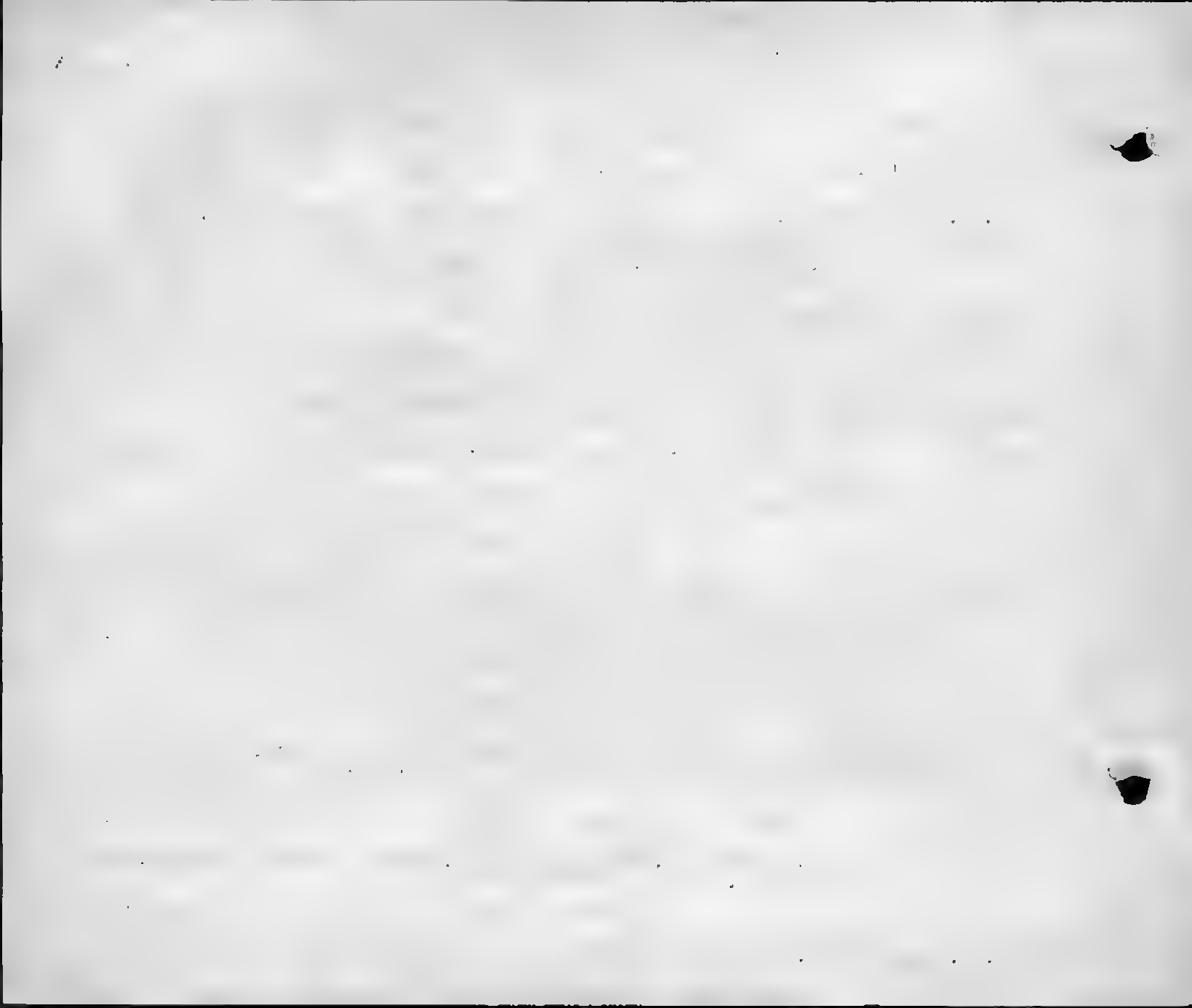
4443

04435

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 458 Oak Wood Street, S. W. d. STREET ADDRESS 458 Oak Wood Street, S. W.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN It 10 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jeffrey David CRAIG		4. DATE OF DEATH April 21 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-20-61	
9. AGE, in years ast birth day yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 9 59	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11b. KIND OF BUSINESS OR INDUSTRY		11. PLACE County & State or foreign country Maryland USA	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert M. CRAIG		14. MOTHER'S MAIDEN NAME Judith Irene SILER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Robt. M. Craig, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. Hypertensive Myocardial Disease. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (X) (this hospital) attended the deceased from April 20, 1961 to April 21, 1961, that (I) (we) last saw the deceased alive on April 21, 1961, and that death occurred at 8:10AM, from the causes and on the date stated above.			
22a. SIGNATURE Fred W. GRELLO, LT, MC, USN		22b. DATE SIGNED 4-21-61	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 517 11th St. SE, WashDC		25a. REC'D BY REGISTRAR APR 24 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

51161



CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ss on) a. STATE <u>Conn</u> b. COUNTY <u>New Haven</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naugatuck</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>		d. STREET ADDRESS <u>15</u>	
3 NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>Teresa</u> Last <u>Cross</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>1</u> Year <u>1961</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William F. Kehoe</u>		14 MOTHER'S MAIDEN NAME <u>Mary Brennan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO	
17. INFORMANT <u>Capt. Wm H. Cross 3229 Morris St N.W.</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>232x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)
20f. (City or town) (County) (State)		21 I certify that (I) (this hospital) attended the deceased from <u>Dec 29 1960</u> to <u>April 1 1961</u> . that (I) (we) last saw the deceased alive on <u>April 1 1961</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert B. Havell</u>		22b. DATE SIGNED <u>4-1-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>		22d. ADDRESS <u>5516 Neb. Ave - DC.</u>	
23a. BURIAL CREMATORY, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-4-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St James</u>	23d. LOCATION (City, town, or county) (State) <u>New Haven County Conn.</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Pumphrey</u>		25a. REC'D BY REGISTRAR <u>APR 6 '61</u>	
ADDRESS <u>7557 Wisc Ave Beth Md</u>		25b. REGISTRAR'S SIGNATURE <u>W. L. H. H.</u>	

24 FUNERAL DIRECTOR'S SIGNATURE
Robert A Pumphrey

ADDRESS
7557 Wisc Ave Beth Md

25a. REC'D BY REGISTRAR
DATE APR 6 '61

25b. REGISTRAR'S SIGNATURE
W. L. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

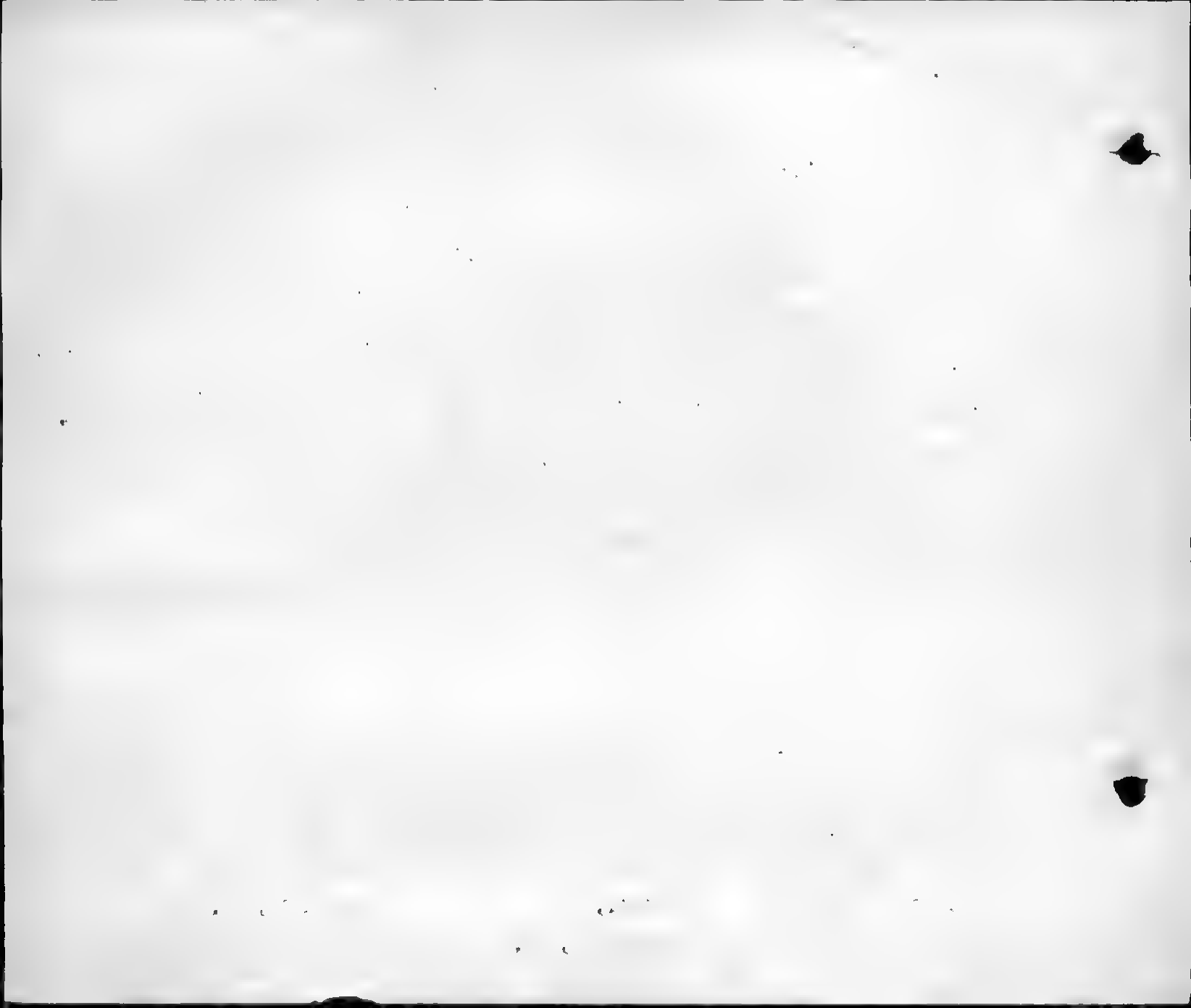
4445

4445

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04458

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>		d. STREET ADDRESS <u>205 Martin Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Lottie Marie Gutchfield</u>		4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1888</u>
9. AGE (In years lost birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte (unknown)</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16 SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Pauline Ellison daughter</u>		Address <u>16 Moore Dr. Rockville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 31X DUE TO <u>Cerebral Arteriosclerosis</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Occlusive Disease</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21 I certify that (I) <u>(the hospital)</u> attended the deceased from <u>6-12</u> , 19 <u>60</u> , to <u>4-25</u> , 19 <u>61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4-25</u> , 19 <u>61</u> , and that death occurred at <u>10:35 A</u> , from the causes and on the date stated above			
22a SIGNATURE <u>Colville J. Jackson</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) <u>Colville J. Jackson</u>		22d ADDRESS <u>202 Martin Lane, Rockville, Md.</u>	
22e DATE SIGNED <u>4-25-61</u>			
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>4/27/61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Balti.</u>		23d LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworde</u>		ADDRESS <u>Rockville, Md.</u>	
25a REC'D BY REGISTRAR <u> </u>		25b REGISTRAR'S SIGNATURE <u>Clarence S. Kraus</u>	
DATE <u>MAY 2 '61</u>			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, or, Page 4 should be forwarded to the Chief Medical Examiner's office along with Form 103. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

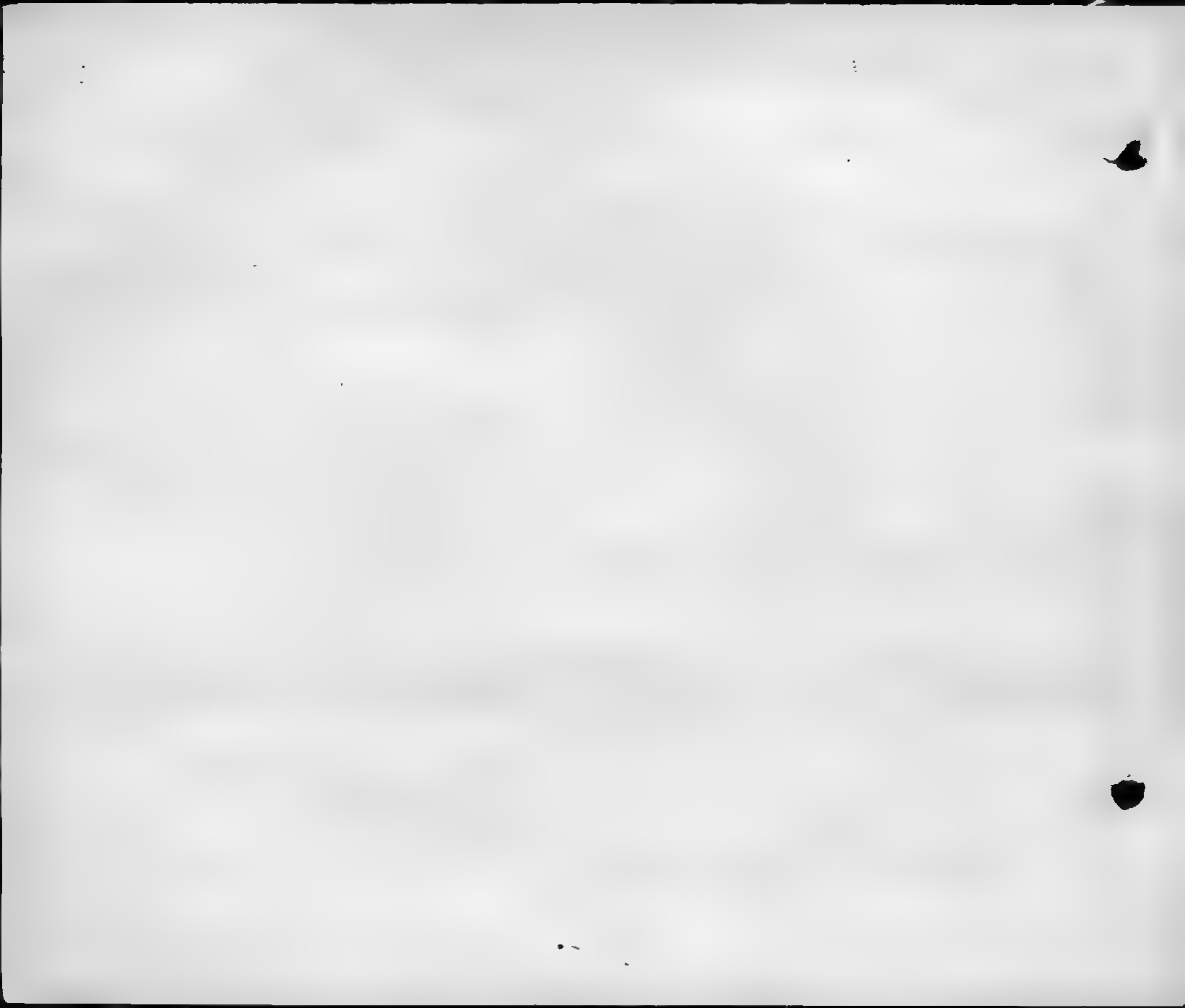
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04438

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>	
c. LENGTH OF STAY IN 1b <u>1 wk</u>		d. STREET ADDRESS <u>S. X - 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Acorn Acres Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Molly P. Cummings</u>	4. DATE OF DEATH <u>Apr 23 1961</u>	f. AGE (In years, last birthday) <u>45</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. IF UNDER 24 HRS. <u>0</u> Hrs. <u>0</u> Min.	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>va</u>	
11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>William E. Williams</u>		14. MOTHER'S MAIDEN NAME <u>May Pinchney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nursing Home Record</u>	
17. INFORMANT <u>Nursing Home Record</u>		Address <u>Nursing Home Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral failure</u> 153.3. DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>C. A. of upper intestinal tract with metastasis</u> (c) <u>metastasis</u> DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a), (b), and (c)			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broadhurst</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broadhurst</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>US National</u>		22d. LOCATION (City, town, or country) (State) <u>Annapolis</u>	
23. FUNERAL DIRECTOR <u>Bernard Herdady Salisbury, Md.</u>		24a. REC'D BY REG. STAFF <u>DATE MAY 2 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE SIGNED <u>4-24-61</u>	

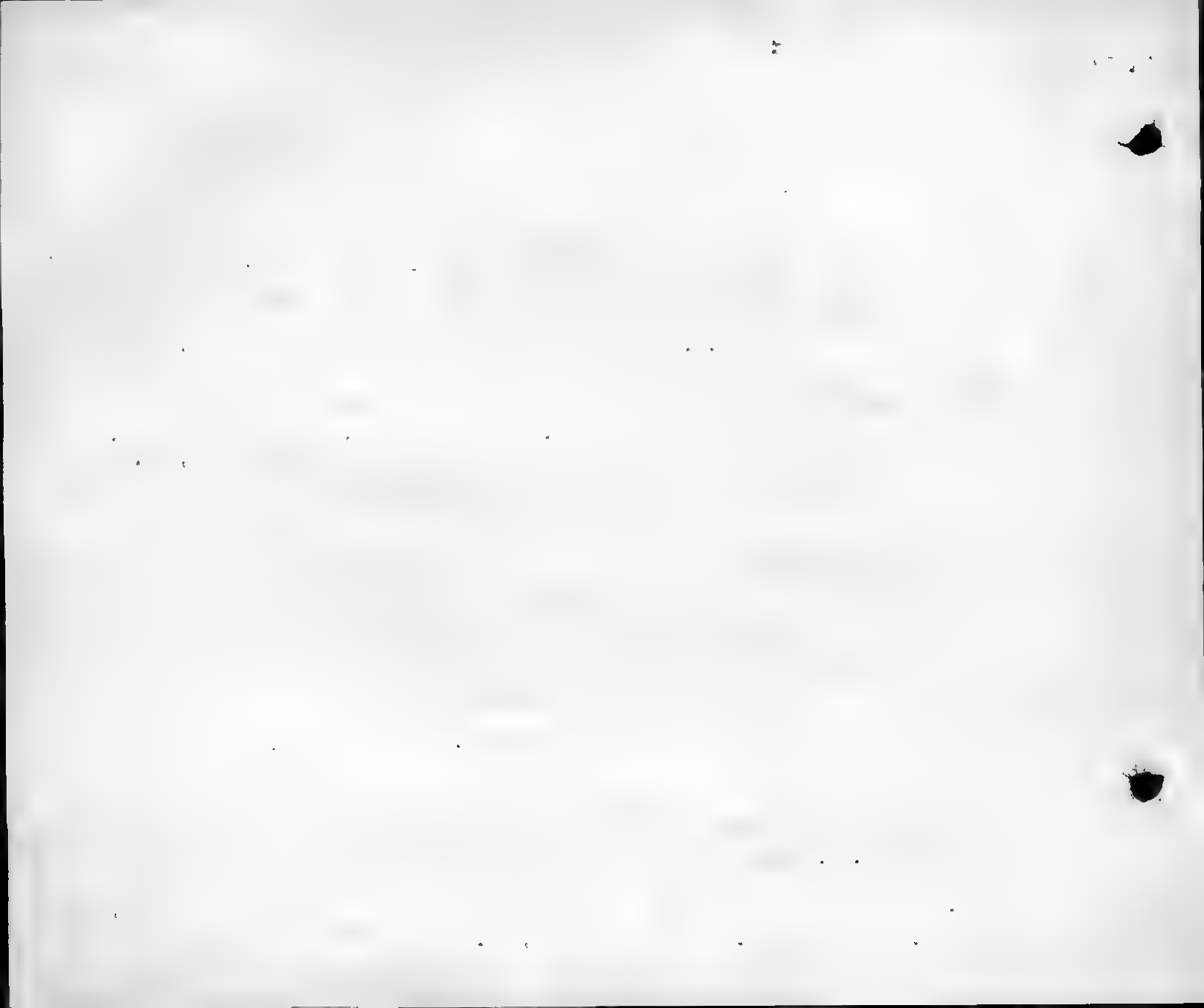
MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH minutes



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME		d. STREET ADDRESS 3802 THORNAPPLE STREET	
3. NAME OF DECEASED (Type or print) First John Middle Albert Last Davis		4. DATE OF DEATH Month April Day 12 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1861
9. AGE (In years lost birthday) 99 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTMASTER		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT	
11. BIRTHPLACE (State or foreign country) XXXXXXXXXXXX OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Davis		14. MOTHER'S MAIDEN NAME Mary XXXXXXXXXX HOSKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Roy Tasco Davis, 3802 Thornapple St. Chevy Chase, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia Bronchial 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1st Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 4 1961, to April 12 1961, that (I) (we) last saw the deceased alive on April 11 1961, and that death occurred at 12 AM , from the causes and on the date stated above.			
22a. SIGNATURE W. B. Warrup		22b. DATE SIGNED 4/12/61	
22c. PHYSICIAN'S NAME (Type) W. B. WARRUP		22d. ADDRESS 800 Pershing Drive, Silver Spring, Md.	
23a. BURIAL CREMATION, DATE THEREOF TRANS. & BURIAL 4/17/61		23b. NAME OF CEMETERY OR CREMATORY MENDSCINO CEMETERY	
23c. LOCATION (City, town or county) (State) PARLETER, FRESNO COUNTY, CALIFORNIA		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Purnicey, INC. Raymond A. Ziska		25a. REC'D BY REGISTRAR APR 19 '61	
25b. REGISTRAR'S SIGNATURE C. L. S. Kraw		25c. REGISTRAR'S SIGNATURE	

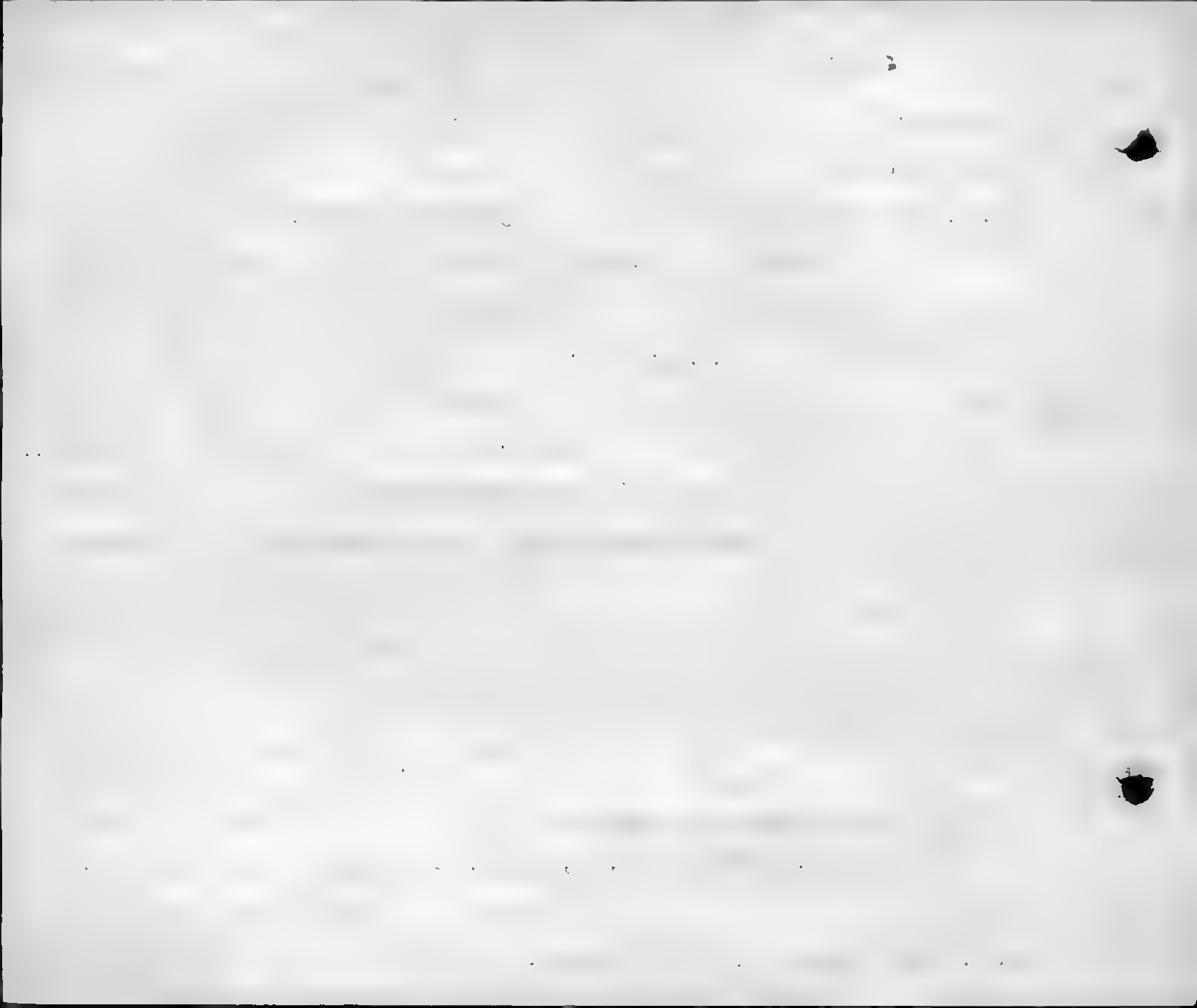


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3443 **MARYLAND STATE DEPARTMENT OF HEALTH** **DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND** **CERTIFICATE OF DEATH**

04440

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY District of Columbia	
c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 3295 Arcadia Place, N. W.	
3. NAME OF DECEASED (Type or print) William Salvatore		4. DATE OF DEATH April 30 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-1870	
9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS., list birthday) Months Days Hours M n. 90 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Sergeant	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1897 to 1921 None		16. SOCIAL SECURITY NO (D) Mrs. Katherine E. Gass, 4500 S. Capital St.	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO <i>arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (b) <i>arteriosclerotic heart disease</i> (c) <i>arteriosclerotic heart disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		18. INTERVAL BETWEEN ONSET AND DEATH 1 year	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) 20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)		20e. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from April 29 1961 to April 30, 1961 that (I) (we) last saw the deceased alive on April 30 1961 and that death occurred at 3:52 AM, from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Linaweaver, LT, MC, USN		22b. DATE SIGNED 5-1-61	
22c. PHYSICIAN'S NAME (Type) Paul G. LINAEWEAVER, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-4-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Pennsylvania Ave, SE, WashDC	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAY 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04441

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN b. <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Key West</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Key West</u> d. STREET ADDRESS <u>WLE Rest Beach</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Anne</u> Last <u>DENNY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>11-30-60</u> 9. AGE (In years last birthday) <u>1</u> yrs. <u>4</u> months <u>18</u> days		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Arkansas</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carleton Edgar DENNY</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Anne HUFFMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>(F) C. E. Denny, same as #2 above</u> Address _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>754</u> IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> DUE TO (b) <u>(Transposition of Great Vessels)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour <u>19</u> a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 30</u> , 19 <u>61</u> , to <u>April 18</u> , 19 <u>61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 18</u> , 19 <u>61</u> , and that death occurred at <u>10AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>C. W. Bramlett</u> 22c. PHYSICIAN'S NAME (Type) <u>C. W. BRAMLETT, LT, MC, USN</u>		22b. DATE SIGNED <u>4-18-61</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial-Shipment</u> <u>4-19-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Delight Cemetery</u> 23d. LOCATION (City, town or county) <u>Delight</u> (State) <u>Arkansas</u>		25a. REC'D BY REGISTRAR <u>APR 19 1961</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u> 24b. ADDRESS <u>Funeral Home, Bethesda, Md.</u>			

VE AB (A)
 MM 9160



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4450

04442

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY N 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if last full one; Residence before admission) a. STATE Florida b. COUNTY Punta Gorda c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Princess Hotel d. STREET ADDRESS Princess Hotel	
3. NAME OF DECEASED (Type or print) John James DONOHUE		4. DATE OF DEATH Month April Day 7 Year 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-23-93	
9. AGE (In years, if UNDER 1 YEAR, last birthday) 67 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		12. PLACE OF BIRTH (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Frank DONOHUE		14. MOTHER'S MAIDEN NAME Bridget MC KEEVER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI- WWII		16. SOCIAL SECURITY NO 015-24-4865	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma pancreas- metastatic DUE TO (b) 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4 mo PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
21. I certify that (this hospital) attended the deceased from March 28 , 19 61 to April 7 , 19 61 , that (s) (we) last saw the deceased alive on April 7 , 19 61 , and that death occurred at 11AM , from the causes and on the date stated above.		22a. SIGNATURE B. H. Rice 22c. PHYSICIAN'S NAME (Type) B. H. RICE, LT, MC, USN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 11 APR 61	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town or county) (State) Delaware County, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		25a. REC'D BY REGISTRAR APR 11 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. DATE APR 11 '61	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04443

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Needwood Rd.</u>		d. STREET ADDRESS <u>437 Gaither St</u>	
3. NAME OF DECEASED (Type or print) <u>Lucille Violet Dove</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ja</u>	9. AGE (In years last birthday) <u>37</u> yrs.
13. FATHER'S NAME <u>Edward Lee Runyon</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Reese</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-30-6916</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>7x0.1</u> (c) <u>7x0.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>7x0.1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-3-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or country, (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 2 '61</u>	
ADDRESS <u>Laytonsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

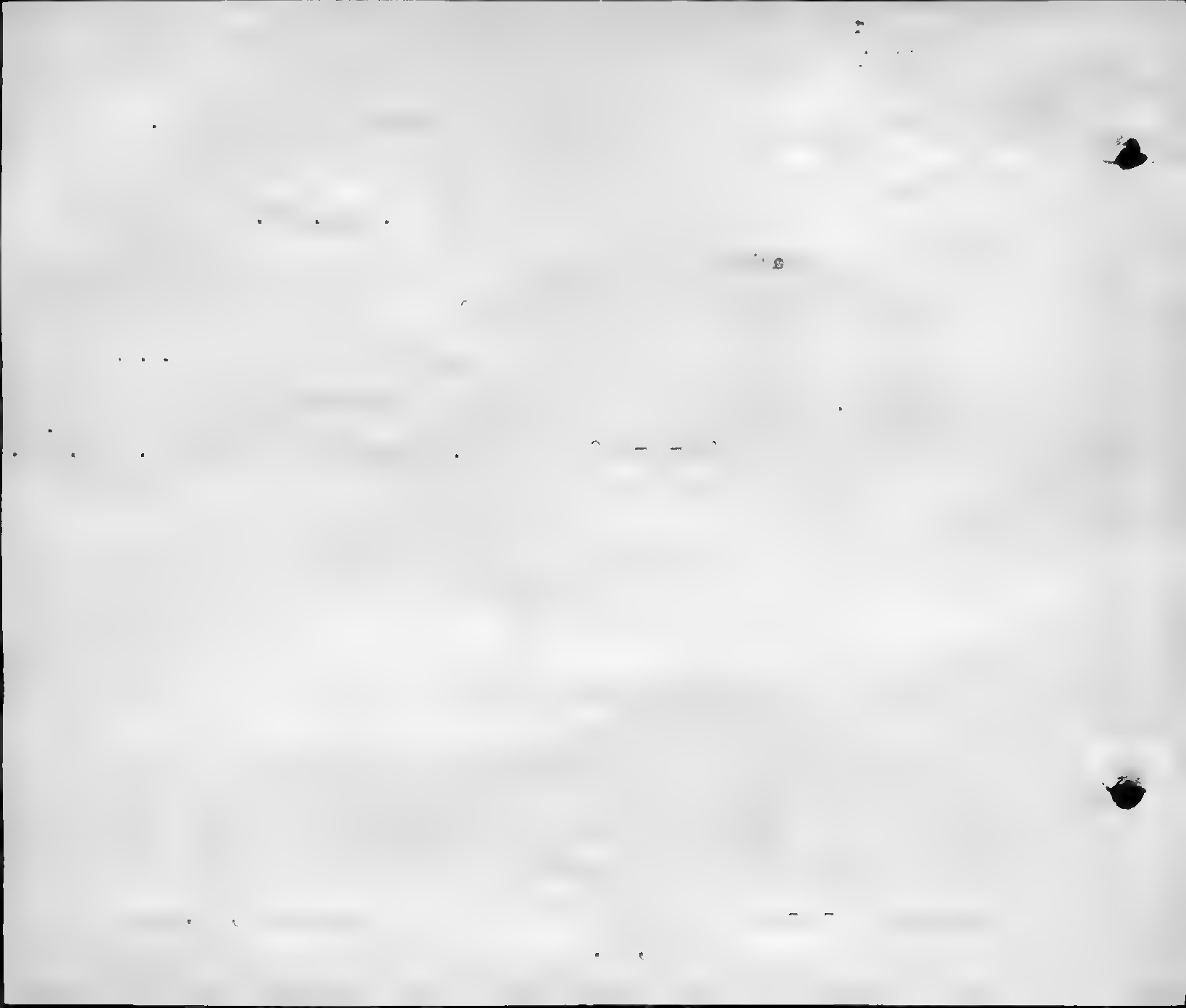
04444

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1257 E. Mont. Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Zachariah</u>				4. DATE OF DEATH <u>April 13 1961</u>			
5. SEX <u>male</u>				6. AGE in years (last birthday) <u>51</u> yrs.			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>				8. DATE OF BIRTH <u>3/5/10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Waiter</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Zachariah T. Duvall</u>				14. MOTHER'S MAIDEN NAME <u>Marion Louise Ward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-03-9932</u>			
17. INFORMANT <u>Howard L. Shores - 2704 Terrapin Rd., Sil. Spr.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>322.1</u> DUE TO <u>Fat embolism</u>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic alcoholism</u>							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-15-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Grove</u>				22d. LOCATION (City, town, or country) (State) <u>Woodfield, Md.</u>			
23. FUNERAL DIRECTOR <u>Lamar H. Barber</u> Laytonsville, Md.				24a. REC'D BY REGISTRAR <u>APR 17 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>C. H. L. Jones</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04445

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLESVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANGLEY PARK</u>			
c. LENGTH OF STAY IN 1b <u>3 YRS.</u>				d. STREET ADDRESS <u>8204 NEW HAMPSHIRE AVE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marlow Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>L.</u> Last <u>EAKINS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 8, 1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTICULAR NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>OTTO BURI</u>				14. MOTHER'S MAIDEN NAME <u>SARAH FITZPATRICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>SISTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocardial Disease</u> (c) <u>Tenacious Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 13, 1961</u> to <u>April 17, 1961</u> that I last saw the deceased alive on <u>April 17, 1961</u> , and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1919 Peninsula Rd Silver Spring, Md</u> DATE SIGNED <u>4-17-61</u>							
ACTUAL SIGNATURE <u>John S Rogers</u> M.D.				PHYSICIAN'S NAME (Type) <u>JOHN S ROGERS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 20, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>ATLANTA, GA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Tatternell</u> ADDRESS <u>3603 14th St NW DC</u>				24a. REC'D BY REGISTRAR <u>DATE PR 19 '61</u>		24b. REGISTRAR'S SIGNATURE <u>James E. Kincaid</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director; page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



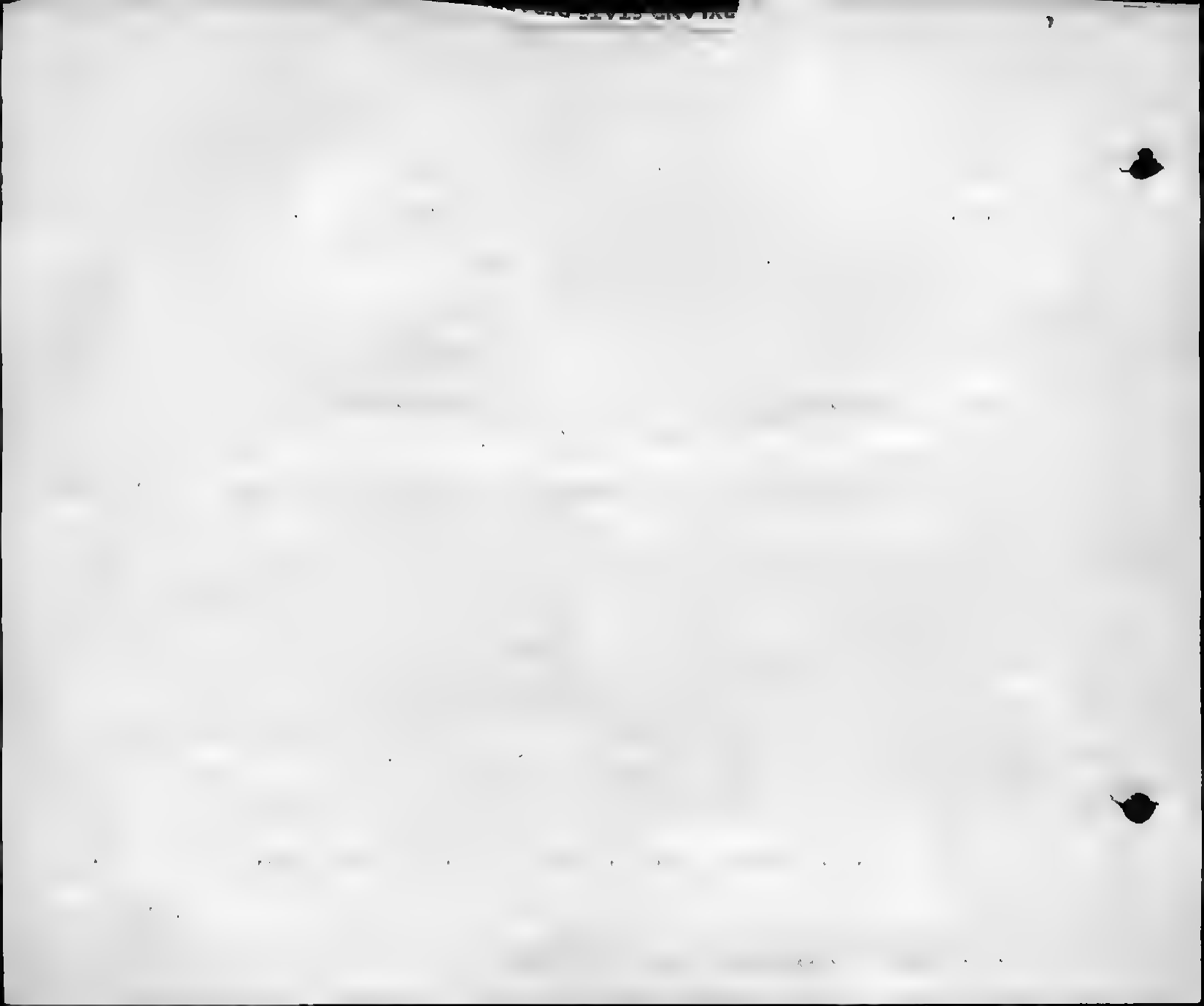
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

4454
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04446

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 70 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 431 Orange St., S. E. d. STREET ADDRESS 431 Orange St., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ellen Ann EFFINGER		4. DATE OF DEATH April 4 1961		5. SEX Female	
6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-13-60	
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 1 Min.		11. BIRTHPLACE (Country & State, or foreign country) Germany	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman R. EFFINGER		14. MOTHER'S MAIDEN NAME Elfriede SCHNEIDER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT (F) N.R. Effinger, same as #2 above		Address	
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease (Truncus arteriosus) 754.5 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH From birth		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 24 1961 to April 4 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 4 1961 , and that death occurred at 10:42AM , from the causes and on the date stated above.		22a. SIGNATURE C. W. BRAMLETT		22b. DATE SIGNED 4-4-61	
22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 APR 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, WashDC	
25a. REC'D BY REGISTRAR APR 6 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kama		25c. DATE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4455 Items 22 & 23 Film G284 4/12/61 iwk

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park D.O.A.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash Sanit Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS 17421 Carroll Ave e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Glenn Elliott
4. DATE OF DEATH 4-2-1961
5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 2-15-25 9. AGE (In years) 36 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 10b. KIND OF BUSINESS OR INDUSTRY Maine 11. BIRTHPLACE (State or foreign country) Maine 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Elliott 14. MOTHER'S MAIDEN NAME Ada Clark
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Old Hospital Record 17. INFORMANT Old Hospital Record Address Old Hospital Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 4/11/61 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Brisenzat M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J. BRISENZAT ASS STANT MEDICAL EXAMINER ☐ DATE SIGNED 4-2-61
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/11/61 22c. NAME OF CEMETERY OR CREMATORY Washington National Cem. 22d. LOCATION (City, town, or country) (State) Suitland, Md.

23. FUNERAL DIRECTOR'S NAME (Type) Cheryl ADDRESS Funeral Home 5103 Wisconsin Ave. N.W. Wash. D.C. 24a. REC'D BY REGISTRAR APR 10 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Frank



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be revised by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

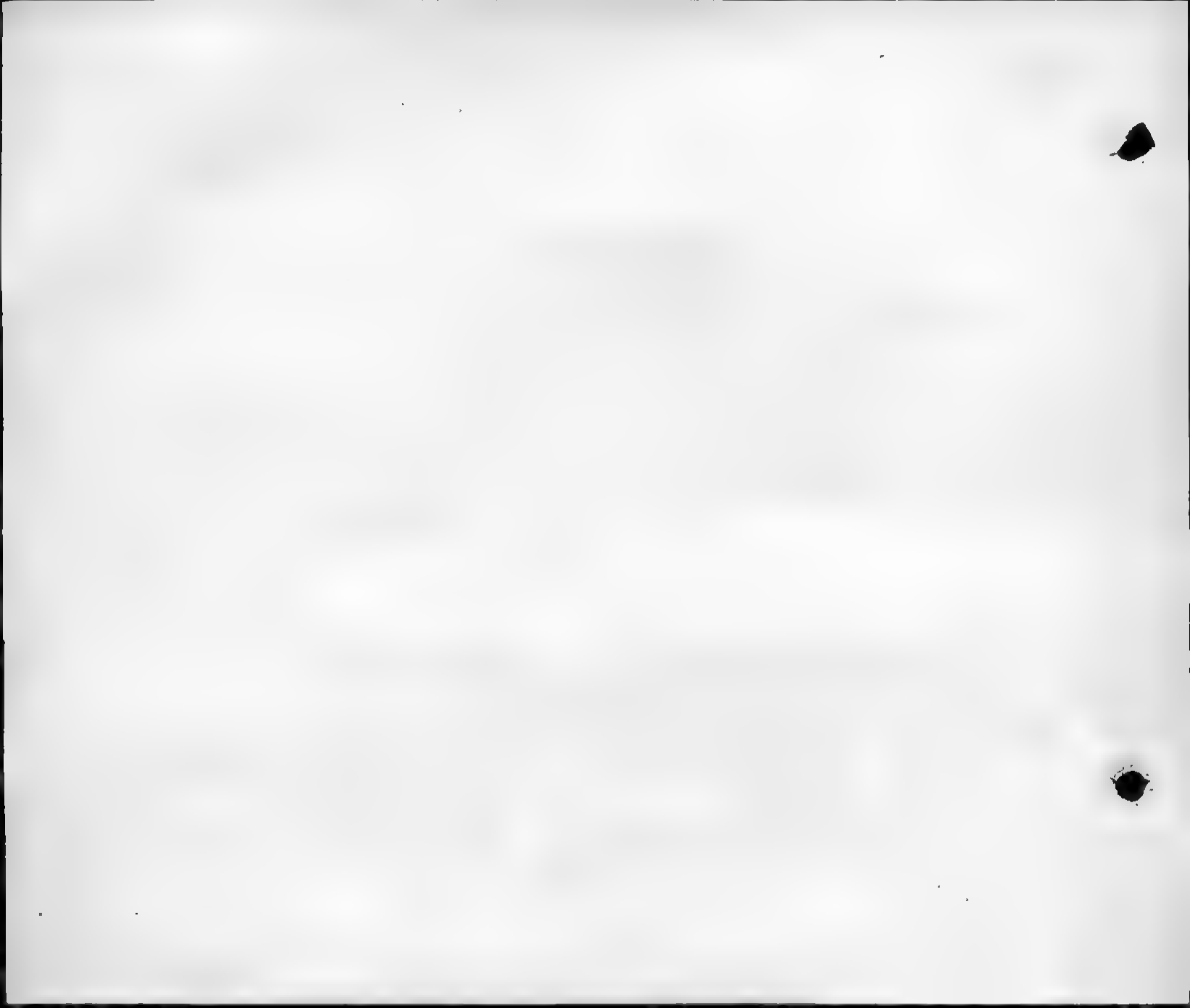
1
4456
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04443

1. PLACE OF DEATH a. COUNTY <u>Montgomery, Bethesda - MARYLAND</u>				2. USUAL RESIDENCE Where deceased lived (if institution, Residence before admission) a. STATE <u>Maryland</u>					
b. CITY OR TOWN (If outside corporate limits, write <u>Bethesda</u> and give nearest town) <u>RESIDORE Sanatoga</u>				c. CITY OR TOWN (If outside corporate limits, write <u>Sumner</u> and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1 Hospital</u>				e. STREET ADDRESS <u>5709 Rockmere Drive</u>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Parthenore</u> Last <u>Engle</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 July, 1885</u>			
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>					
13. FATHER'S NAME <u>Elwinfield Scott Parthenore</u>				14. MOTHER'S MAIDEN NAME <u>Early</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>					
17. INFORMANT <u> </u>				Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u> </u>			
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1959</u> to <u>4-28-1961</u> , that (I) (we) last saw the deceased alive on <u>4-28-1961</u> , and that death occurred <u>10:55 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>C. P. Ryland</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-28-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. P. RYLAND</u>				22d. ADDRESS <u>4400-49th ST. Wash 16 DC.</u>					
23a. BURIAL CREMATION <u>Removal</u>				23b. DATE THEREOF <u>5/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Harrisburg Cemetery</u>			
23d. LOCATION (City, town, or county) <u>Harrisburg, Penna.</u>				23e. REC'D BY REGISTRAR <u> </u>		23f. REGISTRAR'S SIGNATURE <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. F. Thiney Co.</u>				ADDRESS <u>2901-14th ST. N.W.</u>		25a. REC'D BY REGISTRAR <u>MAY 1 '61</u>			
25b. REGISTRAR'S SIGNATURE <u> </u>				25c. REGISTRAR'S SIGNATURE <u> </u>					

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled into the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04449

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY (In 1 b) <u>2 days + 14 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Saintadium Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if inst. tutage, Res. denot. before admision) a. STATE <u>Maryland</u> b. COUNTY <u>George's</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Lexington Park</u> d. STREET ADDRESS <u>Town Creek Manor</u>	
3. NAME OF DECEASED (Type or print) <u>Howard Herbert Eskridge</u>		4. DATE OF DEATH <u>April 5 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 28, 1911</u>
9. AGE (In years last birthday) <u>49</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Eskridge</u>		14. MOTHER'S MAIDEN NAME <u>Elsa TRAKELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.2</u>		16. SOCIAL SECURITY NO <u>213-07-3782</u>	
17. INFORMANT <u>Mrs. Howard H. Eskridge</u>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. (City or town, County, State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-2-61</u> to <u>4-4-61</u> , that (I) (we) last saw the deceased alive on <u>4-4-61</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Aldo Vacca</u>		22b. DATE SIGNED <u>4-5-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aldo VACCA</u>		22d. ADDRESS <u>1429 University Blvd, W. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial April 8, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>		23e. REC'D BY REGISTRAR	
24. FUNERAL DIRECTOR'S SIGNATURE		25. REGISTRAR'S SIGNATURE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 7/59

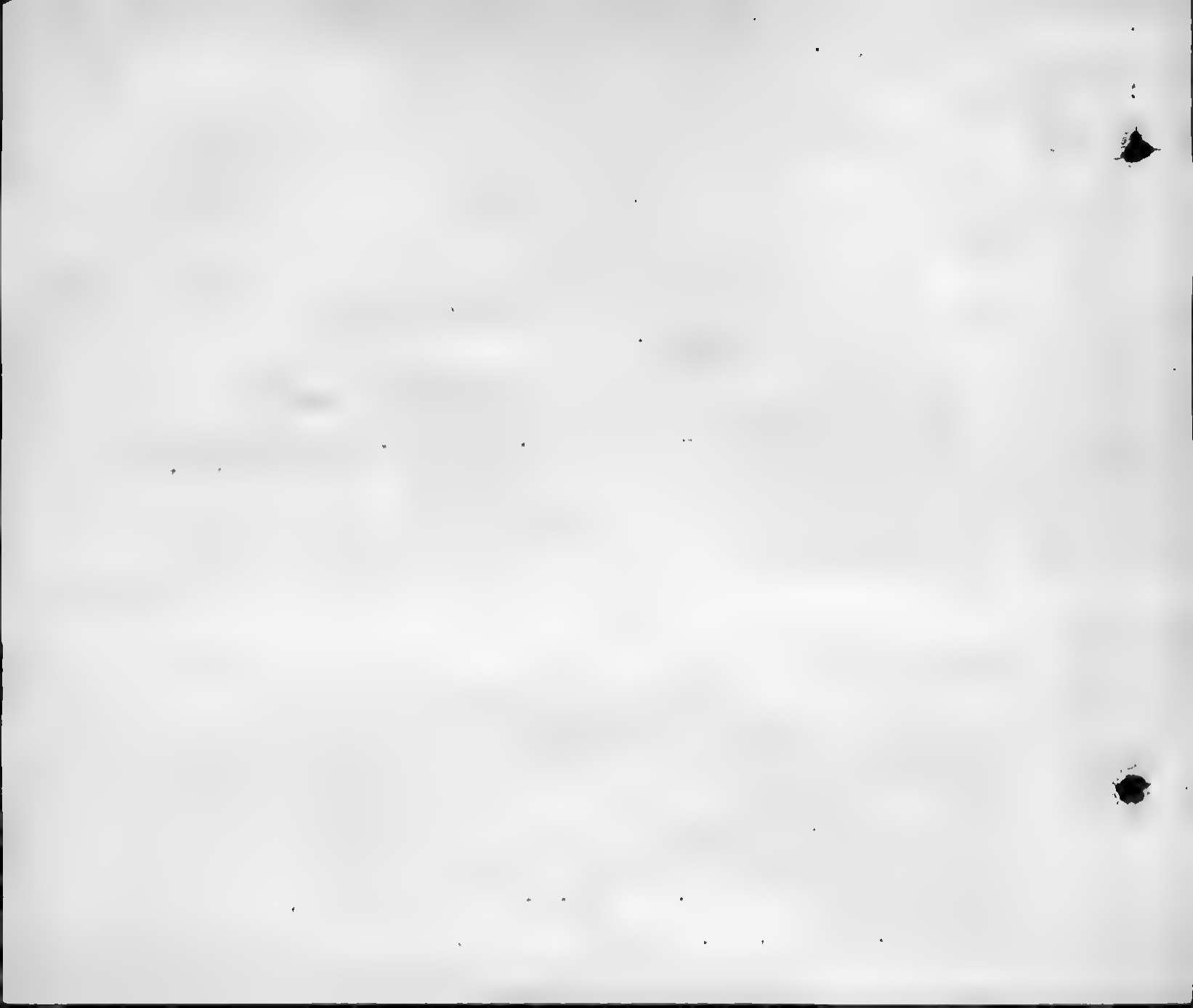
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MEADOWOOD</u>	
c. LENGTH OF STAY IN TB <u>30 min</u>		d. STREET ADDRESS <u>23 Thomas Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sen + Hosp</u>			
3. NAME OF DECEASED (Type or print) <u>Alfred Lee Everhart</u>		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>W</u>	6. COLOR OR RACE <u>M</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXXXX 2/1/14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Donald S. Hay Construction Firm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS EVERHART</u>		14. MOTHER'S MAIDEN NAME <u>McCrossin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-03-0471</u>	
17. INFORMANT <u>Mrs. Eleanore M. Everhart, 23 Thomas Drive</u>		Address <u>Meadowood, Md.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschiat</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschiat</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/8/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel M. P. Church Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Sunshine, Maryland</u>	
23. FUNERAL DIRECTOR <u>Raymond E. Pumphrey, Inc.</u>		24a. REC'D BY REGISTRAR <u>APR 11 '61</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thane</u>	

04450

4-5-61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No

04451

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>+</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 15 <u>3 yrs. + 1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>425 BUTTERNUT ST. N.W.</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BALLS Nursing Home 7420 Maple Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>MAY FENTON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1961</u>		5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/12/1867</u>		9. AGE (In years last birthday) <u>94</u> yrs <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days		Hours		Min	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Clerk</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS														
Months	Days														
	Hours														
	Min														
10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>											
13. FATHER'S NAME <u>William Fenton</u>				14. MOTHER'S MAIDEN NAME <u>Cordelia Walker</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Helet M. Donaldson</u>		17. INFORMANT <u>Helet M. Donaldson</u>		Address <u>425 Butternut St. N.W.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis with Cardiac Failure</u> DUE TO <u>Nephrosclerosis with Uremia</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Undetermined</u> <u>Undetermined</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>June 1, 1947</u> to <u>Apr 5, 1961</u> that I last saw the deceased alive on <u>Apr 4, 1961</u> and that death occurred at <u>2317</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 Sigma Ave Washington D.C.</u> DATE SIGNED <u>Apr 5, 1961</u>															
ACTUAL SIGNATURE <u>George L Ball</u> M.D.		PHYSICIAN'S NAME (Type) <u>George L Ball Silver Spring Md</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4 8 61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glencrest Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Helet Funeral Home</u>				ADDRESS <u>4812 Seagrave Hill</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>									
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4460

04452

M

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

4510 Drummond Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

55 Chevy Chase

d. STREET ADDRESS

4510 Drummond Ave.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

ORLINE

FENWICK

DATE OF DEATH

Month

April 14,

Day

Year

19 61

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

June 1, 1883

9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours M.n.

77 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

New Orleans, La.

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Ignatius J. Fenwick

14. MOTHER'S MAIDEN NAME

Julia Duncan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

None

Ruth S. Daly

Address

1608 East-West Highway
Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

153.8

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Generalized atherosclerosis - sclerotic

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from... March 1960 to April 14, 1961, that (I) (we) last saw the deceased alive on... April 13, 1961 and that death occurred at 4:45 PM, from the causes and on the date stated above.

22a. SIGNATURE

John V. Dolan

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

4-14-61

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

JOHN V. DOLAN

22d. ADDRESS

3100 Conn. Ave., N.W., Washington,

23a. BURIAL, CREMATION REMOVAL (Specify)

Burial

23b. DATE THEREOF

4-17-61

23c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

23d. LOCATION (City, town or county)

Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE

ROBERT A. PUMPHREY

ADDRESS

Bethesda, Md.

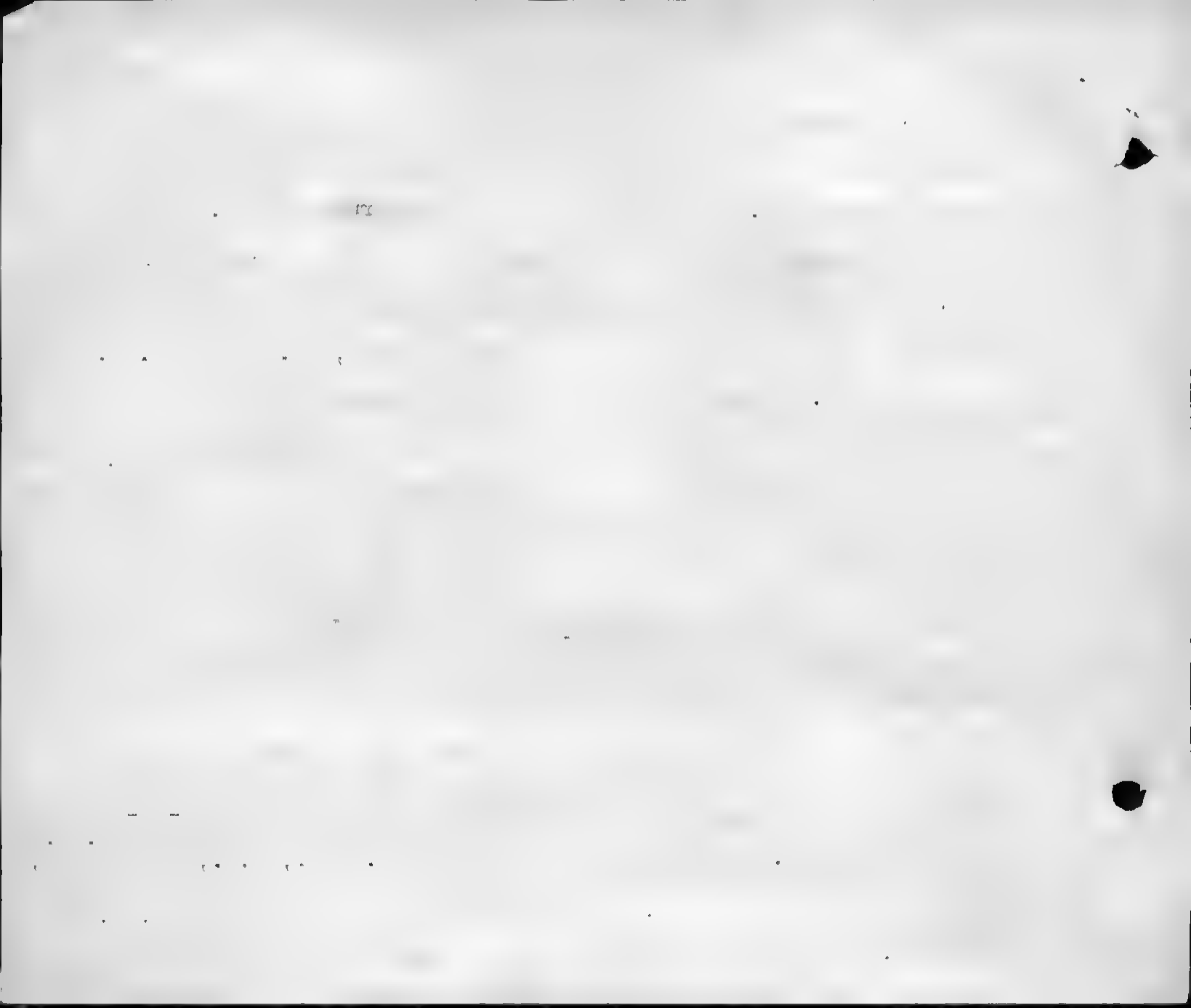
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE APR 19 '61

Arthur L. Frank

VR A15 (4)
15M 9/60



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 will be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MD
4461

4453

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if not within residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>19131 Aldershot Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Caroline</u> 4. DATE OF DEATH <u>Apr 16 1961</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-1877</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>Iowa</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Mr Mitchell</u> 14. MOTHER'S MAIDEN NAME <u>Duschny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Nursing Home Record</u> Address <u>Duschny</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO (b) <u>RIGHT COMMON ILIAC PHLEBOTHROMBOSIS, COMPLETE</u> DUE TO (c) <u>POSTOPERATIVE CONDITION FOLLOWING SURGERY FOR HIP FRACTURE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>-</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> days		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Refractured pelvis on floor at home</u> 20c. TIME OF INJURY Month, Day, Year <u>3-21-1961</u> Hour a.m. <u>-</u> p.m. <u>-</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>4-16-61-</u>		ACTUAL SIGNATURE <u>Frank J. Brosehart</u> EXAMINER'S NAME (Type) <u>FRANK J. Brosehart</u> DATE SIGNED <u>4-16-61-</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>April 17, 1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Crematory</u> 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>		23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> 24a. REC'D BY REGISTRAR <u>APR 21 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04454											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Res. since before adm. ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>						d. STREET ADDRESS <u>6402 Vinewood Road</u>					
3. NAME OF DECEASED (Type or print) <u>La Verne C Fisher</u>						4. DATE OF DEATH <u>April 20th, 1961</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Jan. 22-1929</u>					
9. AGE (In years last birthday) <u>32</u> yrs.						10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M.n.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>						11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Clarence Hagberg</u>					
14. MOTHER'S MAIDEN NAME <u>Verna (Unknown)</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>Unknown</u>						17. INFORMANT <u>Joseph J Fisher (husband)</u> Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Collegen-Vascular disease - type undetermined</u> DUE TO (b) <u>Myocarditis - type undetermined</u> DUE TO (c) <u>Myocarditis - type undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>4/25/61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>						22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						24a. REC'D BY REGISTRAR <u>APR 25 '61</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>						DATE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

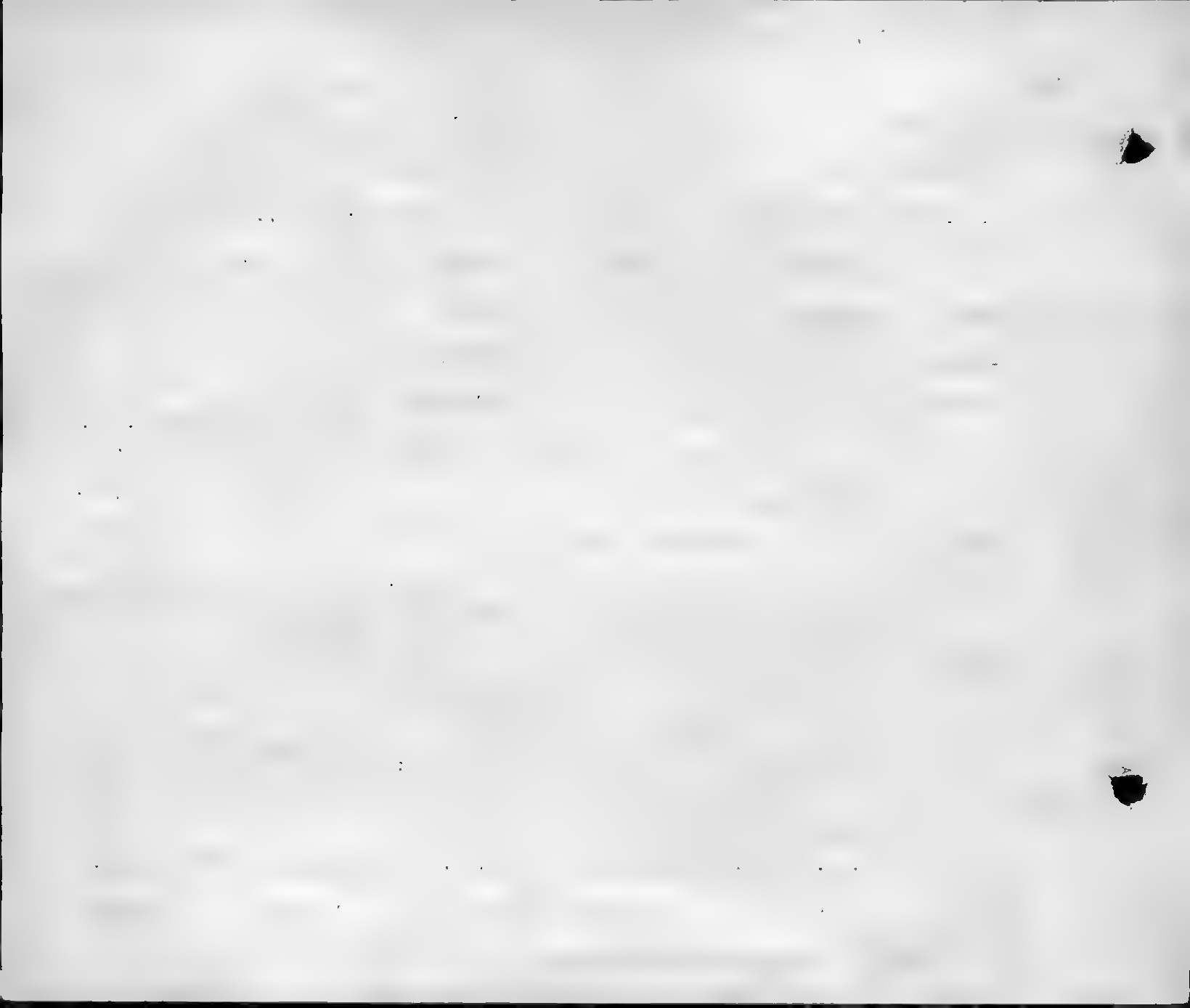
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4463

04455

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN IL 11 days		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3100 Connecticut Ave., NW, Apt. 412		d. STREET ADDRESS Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) Christine Neal		F. First Middle		Last FLEMING		4. DATE OF DEATH April 25 19 61		5 SEX Female		6 COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-94		9. AGE (In years) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John NEAL		14. MOTHER'S MAIDEN NAME Mary DAVIS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (H) Clifford E. Fleming, 7505 Exeter Rd.		Address Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Rheumatic Fever (c) Arteriosclerotic Heart Disease		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. Years Years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21. I certify that (H) (this hospital) attended the deceased from April 14, 1961 to April 25, 1961 that (H) (we) last saw the deceased alive on April 25, 1961, and that death occurred at 8:05 AM, from the causes and on the date stated above.		22a. SIGNATURE J. M. Young, Jr., MC, USN		22b. DATE 4-25-61		22c. PHYSICIAN'S NAME (Type) J. M. Young, Jr., MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-28-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia		24a. REC'D BY REGISTRAR DATE APR 28 '61		24b. REGISTRAR'S SIGNATURE Clifford E. Fleming									
25a. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25b. ADDRESS Funeral Home, Bethesda, Md.		25c. DATE APR 28 '61		25d. REGISTRAR'S SIGNATURE Clifford E. Fleming		25e. ADDRESS Funeral Home, Bethesda, Md.		25f. DATE APR 28 '61		25g. REGISTRAR'S SIGNATURE Clifford E. Fleming		25h. ADDRESS Funeral Home, Bethesda, Md.							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

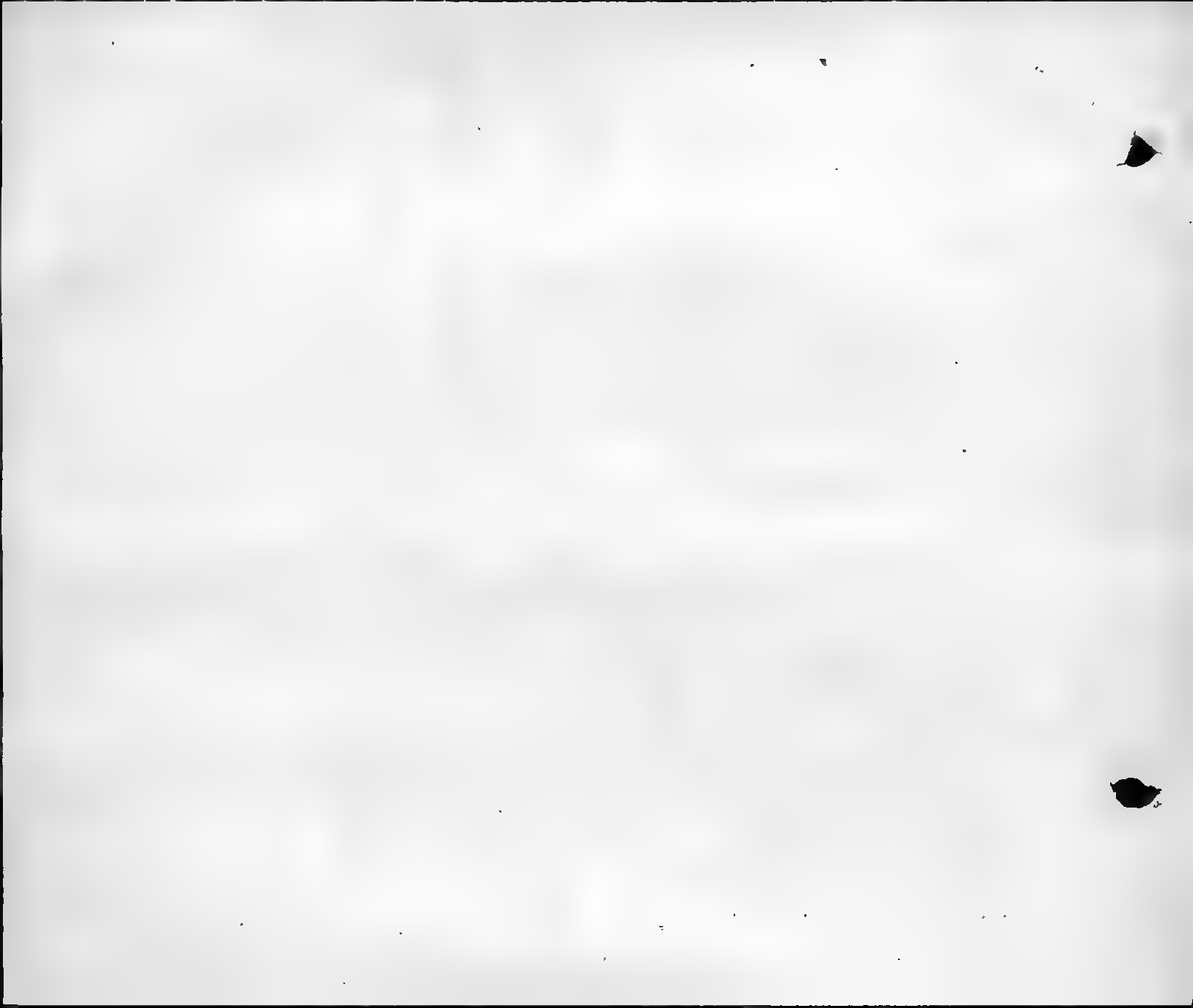
CERTIFICATE OF DEATH

Reg. Dist. No. 04456

4464

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHERRY CHASE				c. LENGTH OF STAY IN 1b 7 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4800 MORGAN DRIVE				d. STREET ADDRESS 4800 Morgan Drive			
3. NAME OF DECEASED (Type or print) First MARY Middle CUETARA Last FLEMMING				4. DATE OF DEATH Month April Day 29 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1872	9. AGE (In years last birthday) yrs 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) CLEARFIELD PA	
12. CITIZEN OF WHAT COUNTRY? US				13. FATHER'S NAME JOSEPH CUETARA			
14. MOTHER'S MAIDEN NAME REBECCA BERGER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO			
16. SOCIAL SECURITY NO NO				17. INFORMANT Sister Mrs Frances Murphy			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO 10 yrs (c) DIABETES MELLITUS 13 yrs				INTERVAL BETWEEN ONSET AND DEATH 1 wic			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.	Month Day Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Sept 15, 1958 to April 29, 1961 that I last saw the deceased alive on April 29, 1961 and that death occurred at 8:15 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lewis H Biben M.D.				ADDRESS (Street, city or town, state) 915 17th St NW Wash DC			
PHYSICIAN'S NAME (Type) LEWIS H BIBEN				DATE SIGNED 4/29/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 5/4/61		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Clearfield, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE May 3 '61	
				24b. REGISTRAR'S SIGNATURE <i>William S. Pumphrey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

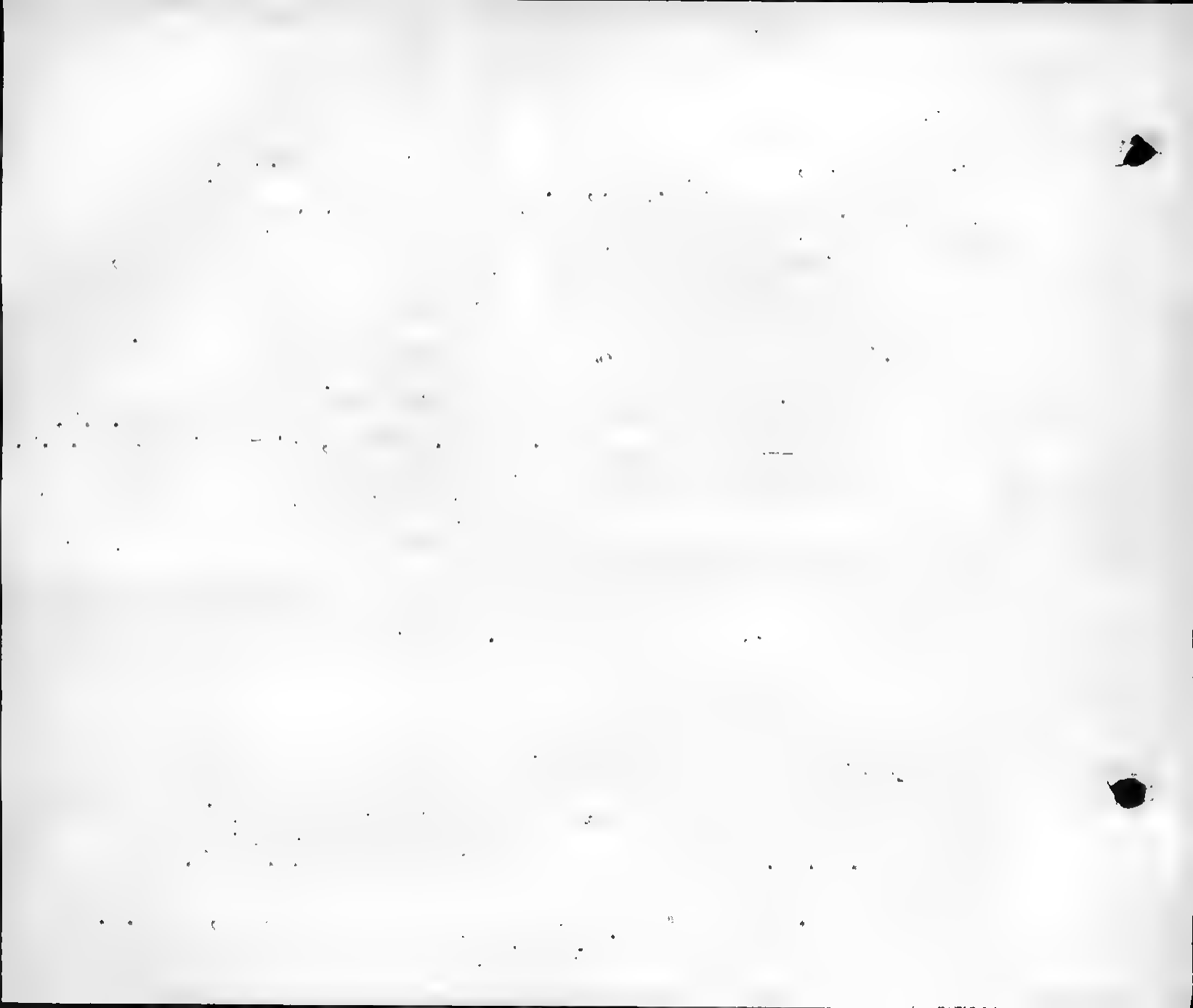


Reg. Dist. No.

04457

Page 4

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D of C b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN 1b 11. Spg., Md.		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 5441 Nebraska Ave. N.W.		d. STREET ADDRESS 1000 Daleview Dr. Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital give street address) Althea Woodland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (GEORGINA) First Georgina Middle Gauntlett Last Francis				4. DATE OF DEATH Month APRIL Day 26 Year 1961			
5. SEX Fe		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-68	
9. AGE (In years last birthday) 92 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? England		13. FATHER'S NAME Charles Gauntlett		14. MOTHER'S MAIDEN NAME Georgina Bailey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT MR. JOHN A. FRANCIS		Address Wash. D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, acute, generalized DUE TO (b) Adenocarcinoma of rectum DUE TO (c)	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)		21. I certify that I attended the deceased from Dec 31, 1945 to April 26, 1961 that I last saw the deceased alive on April 23, 1961 and that death occurred on April 26, 1961 from the causes and on the date stated above.	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 29/61		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas M. Hyson		24a. REC'D BY REGISTRAR APR 28 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Haines		25. DATE SIGNED 4-26-61	



4466

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04458

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 5 DAYS		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. STREET ADDRESS 1717 M St. N.E.		f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle CRESSENTIA Last GEIGER		4. DATE OF DEATH Month APRIL Day 7 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-1869	9. AGE (In years lost birthday) yrs. 91	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY H.W.		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mesle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4-24-61 DUE TO Acute Pulmonary Edema Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO Terminal Pneumonia (c) Terminal Pneumonia INTERVAL BETWEEN ONSET AND DEATH 5 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19, 1961 to April 7, 1961 , that (I) (we) last saw the deceased alive on April 6, 1961 , and that death occurred at 12:00 PM , from the causes and on the date stated above					
22a. SIGNATURE L. I. Leal		M.D. L. I. LEAL, M. D.		22b. DATE SIGNED APR 13 '61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS GAITHERSBURG, MARYLAND			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION (City, town, or county) Suitland Md.		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS Washington D.C.		25a. REC'D BY REGISTRAR APR 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna					

(I)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4467

CERTIFICATE OF DEATH

Reg. Dist. No. 04453

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>8 1/2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6612 Allegheny Ave</u>				d. STREET ADDRESS <u>6612 Allegheny Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Ellen Giddings</u>				4. DATE OF DEATH Month Day Year <u>April 21 1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug-18, 1873</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Ashton T. Coburn</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ann Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Lottie C. Carter (Daughter) Same as deceased.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> DUE TO <u>4500</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>28 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1956</u> to <u>April 21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 14</u> , 19 <u>61</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>2217 Carroll Ave</u> DATE SIGNED <u>4-21-61</u>			
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>				TAKOMA PARK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnnie Walker</u>				ADDRESS <u>254 Carroll St.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			



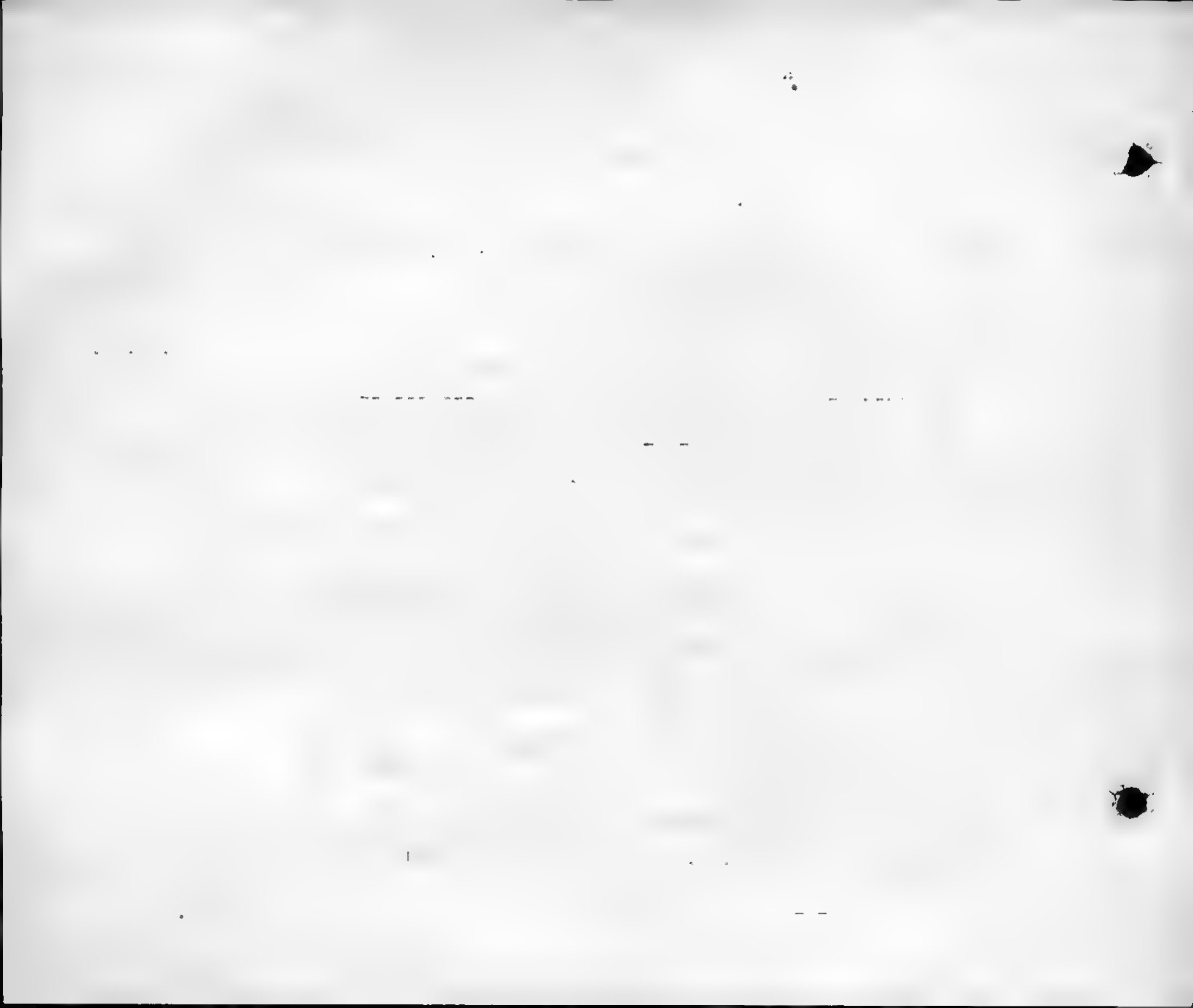
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

4468
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04460

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG			
				d. STREET ADDRESS 600 ROSE ANN PLACE			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last LOUIE CHARLTON GILLIAM				4. DATE OF DEATH Month Day Year APRIL 7 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/31/84	
9. AGE (In years lost birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME -----				14. MOTHER'S MAIDEN NAME -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 214-10-5861		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 HEART FAILURE DUE TO MASSIVE MYOCARDIAL INFARCTION 3 days DUE TO Generalized Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 4, 1961, to April 7, 1961, that (I) (we) last saw the deceased alive on April 4, 1961, and that death occurred at 10:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Francis R. Leal				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4/7/61	
22c. PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.				22d. ADDRESS GAITHERSBURG, MARYLAND			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-9-61		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE APR 10 '61	
						25b. REGISTRAR'S SIGNATURE Arthur E. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04461

1. PLACE OF DEATH
a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY (If not in hospital, give street address) 9 hours

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6001 Berkshire Drive

3. NAME OF DECEASED (Type or print) Louise Whipp 4. DATE OF DEATH April 18 1961

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 12/30/86 9. AGE (In years last birthday, Months, Days, Hours, Min.) 74 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Ohio 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin Franklin Whipp 14. MOTHER'S MAIDEN NAME Gertrude Swickard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 8001 Berkshire Drive Bethesda, Maryland 17. INFORMANT Mrs. Betty Meeds

18. CAUSE OF DEATH (Enter only one cause per I, II, or III)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Cerebrovascular Accident
331X DUE TO Cerebrovascular degeneration
Condition (if any, gave rise to immediate cause (e), stating the underlying cause last.)
DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year April 18 1961 20d. INJURY OCCURRED While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4740 Chevy Chase Dr. Chevy Chase, Md. 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from... to... that (I) (we) last saw the deceased alive on... and that death occurred at... from the causes and on the date stated above.

22a. SIGNATURE George A. Gray, Jr. M.D. 22b. DATE SIGNED April 18 1961

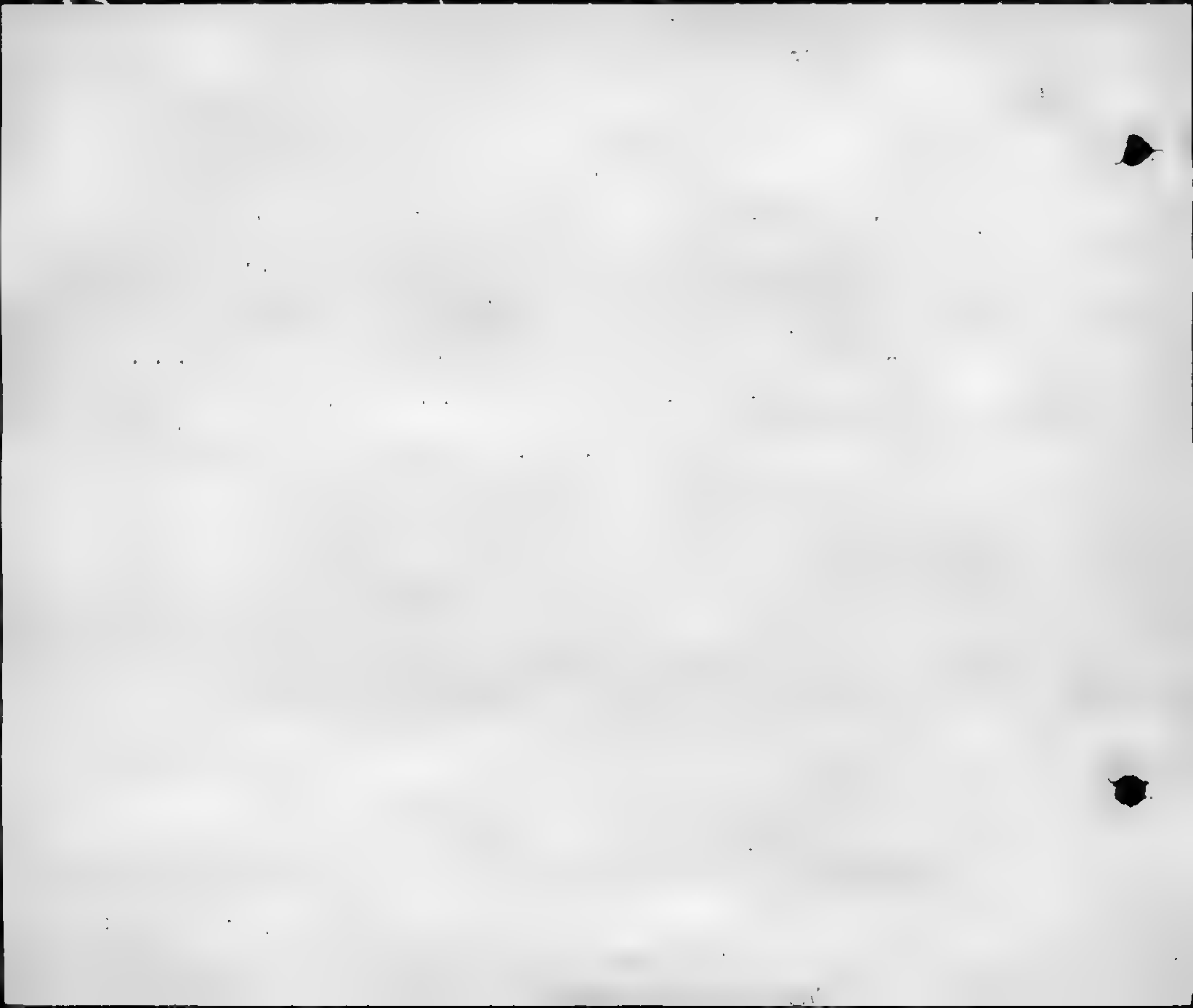
22c. PHYSICIAN'S NAME (Type or print) George A. Gray, Jr. 22d. ADDRESS 4740 Chevy Chase Dr. Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) cremation 23b. DATE THEREOF 4/18/61 23c. NAME OF CEMETERY OR CREMATORY Cert Lincoln Crematory 23d. LOCATION (City, town or county) (State) Columbia, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Blanche Funeral Home ADDRESS 4739 Bell St. Hyattsville, Md. 25a. REC'D BY REGISTRAR APR 21 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

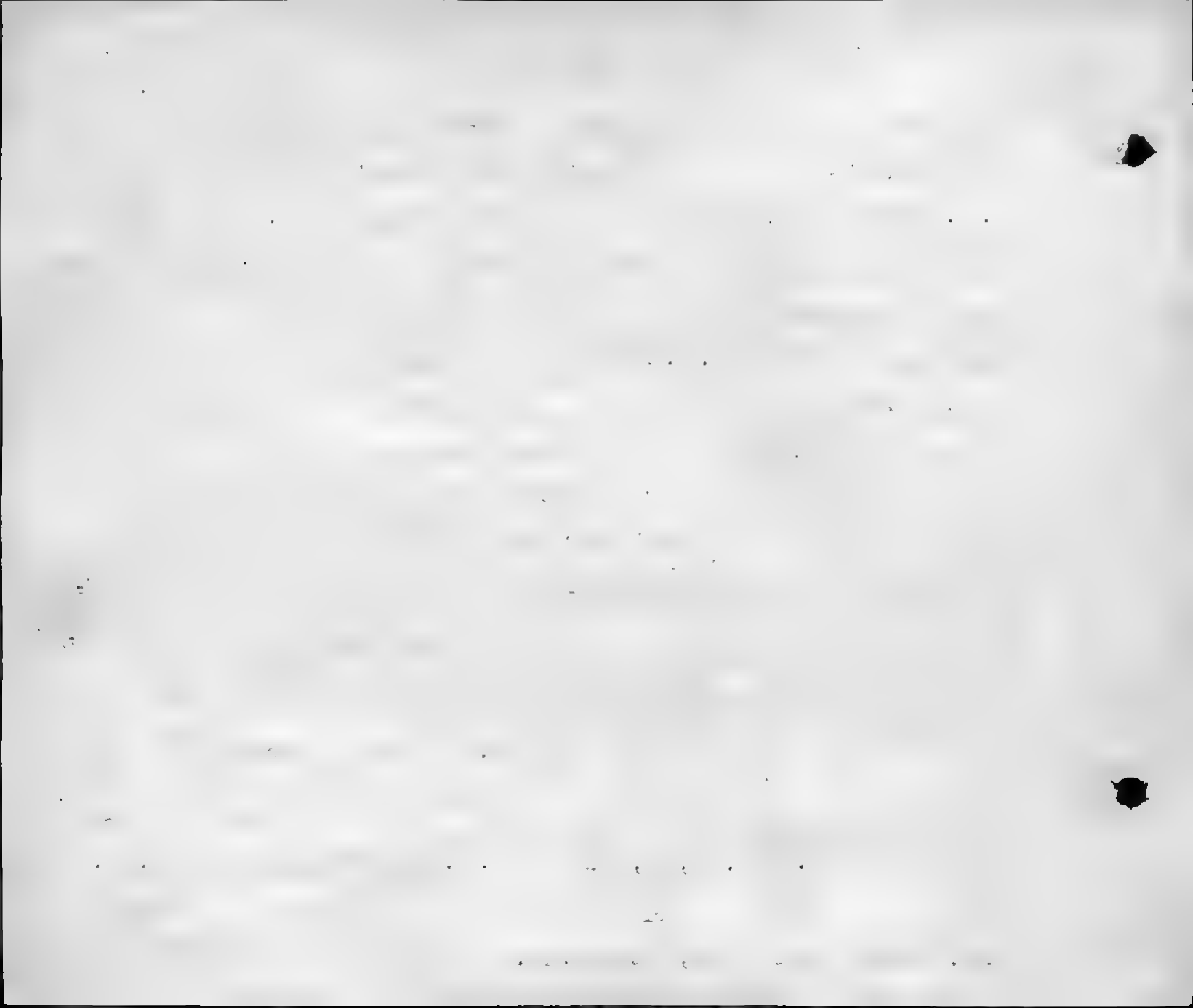
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
Items 14 & 25b, Film G-205 4/24/61.cnc. 04462									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 99 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY St. Petersburg 13 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2530 1/2 Burlington Ave. d. STREET ADDRESS 48X-3				
3. NAME OF DECEASED (Type or print) Louis Ellis GROOT					4. DATE OF DEATH Month April Day 14 Year 19 61				
5. SEX Male					6. COLOR OR RACE Caucasian				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 5-22-87				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner					10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				
11. BIRTHPLACE (County & State, or foreign country) Texas					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William GROOT					14. MOTHER'S MAIDEN NAME Mary STUBAS STUBAUS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWI & WWII					16. SOCIAL SECURITY NO Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion DUE TO (b) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Transitional cell carcinoma, Urinary Bladder PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 6 mos.									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (a) (this hospital) attended the deceased from Jan. 5 19 61 , to April 14 , 19 61 that (a) (we) last saw the deceased alive on April 14 , 19 61 , and that death occurred at 5A M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Jack D. Real</i> 22c. PHYSICIAN'S NAME (Type) Jack D. REAL, LT, MC, USN					22b. DATE SIGNED 4-14-61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23b. DATE THEREOF 4-18-61					23c. NAME OF CEMETERY OR CREMATORY Arlington National				
23d. LOCATION (City, town or county) (State) Arlington Virginia					25a. REC'D BY REGISTRAR DATE APR 18 '61				
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i> R. A. Pumphrey Funeral Home, Bethesda, Md.					25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>				



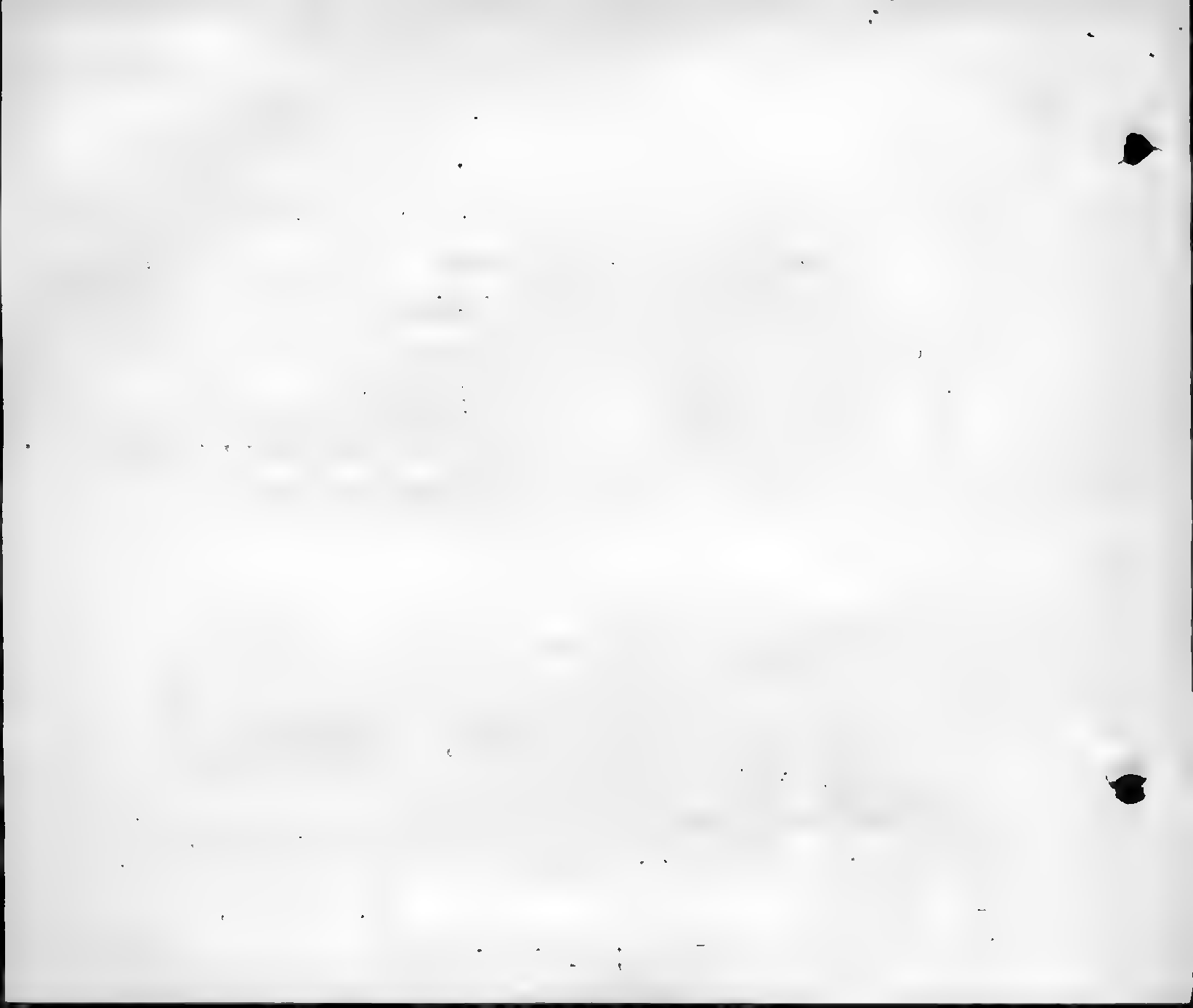
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1471
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04463

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 5 years		d. STREET ADDRESS 438 Emerson St. N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Susan Ida Hamilton		4. DATE OF DEATH Month Apr. Day 3 Year 1961	
5 SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 87 Days 87 Hours 87 Min 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Heflin		14. MOTHER'S MAIDEN NAME Susan Holder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Address Green Acres		Mrs. Fred J. Miller-Neice-Robb. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO 31X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident DUE TO 5 yrs (c) Generalized arteriosclerosis DUE TO ? years		INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 17, 1958 to April 3, 1961 that (I) (we) last saw the deceased alive on April 2, 1961 and that death occurred at 10:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE E. Bowditch Hunter, Jr., M.D.		22b. DATE SIGNED Apr. 3, 1961	
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr., M.D.		22d. ADDRESS 809 Veins Mill Rd., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE APR 6 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	





1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

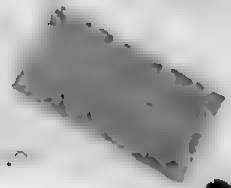
0446

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
c. LENGTH OF STAY in 1b D.O.A.		d. STREET ADDRESS 10404 Montgomery Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawrence First Middle Aloysius Hanley		4. DATE OF DEATH Month Day Year April 22, 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month Day Year May 6, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Life Ins. Broker		10b. KIND OF BUSINESS OR INDUSTRY private	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Cornelius Hanley		14. MOTHER'S MAIDEN NAME Downs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service) Yes 1917-19; 1942-44		16. SOCIAL SECURITY NO. 455-03-0795	
17. INFORMANT Mary Hanley, as above		Address -wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of hypertension + previous heart disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Franz J. Blusch		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BLUSCH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/61	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE APR 25 '61		24b. REGISTRAR'S SIGNATURE Clinton S. Evans	

MEDICAL CERTIFICATION

DATE SIGNED

4-22-61



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4474

04466

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN, if out of corporate limits, write RURAL and give nearest town <u>Wheaton</u> c. LENGTH OF STAY IN IL <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN, if out of corporate limits, write RURAL and give nearest town <u>Silver Spring</u> d. STREET ADDRESS <u>1809 Piney Branch Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Henry</u> Middle <u>Hannan</u> Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-23-71</u></p>		<p>4. DATE OF DEATH <u>APRIL 27</u> 19 <u>61</u> 9. AGE (In years; IF UNDER 1 YEAR, last birthday) <u>87</u> yrs. 10. IF UNDER 24 HRS. Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FIRE INS RATING BUREAU</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>STEELING, ILL.</u> 11. BIRTHPLACE (Country & State or foreign country) <u>AMERICAN</u> 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u></p>		<p>13. FATHER'S NAME <u>LUKE HANNAN</u> 14. MOTHER'S MAIDEN NAME <u>MARY BROWN</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>8009 PINEY BR RD</u> 17. INFORMANT <u>BERNICE E. MCDANIEL</u> Address <u>8009 PINEY BR RD</u></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic leukemia</u> 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>530</u> p.m. <u>00</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>Md.</u></p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>December 1960</u> to <u>April 27, 1961</u>, that (I) (we) last saw the deceased alive on <u>April 18, 1961</u>, and that death occurred at <u>530 A.M.</u> from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u></p>		<p>22b. DATE SIGNED <u>April 27, 1961</u> 22d. ADDRESS <u>9301 Colesville Rd, Silver Spring, Md.</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> 23b. DATE THEREOF <u>4-29-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> 23d. LOCATION (City, town or county) <u>Suitland Md.</u> (State) <u>Md.</u></p>		<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>Dead Funeral Home</u> ADDRESS <u>4812 9th Ave NW</u> 25a. REC'D BY REGISTRAR <u>May 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u></p>	



CERTIFICATE OF DEATH

Reg. Dist. No. 04467

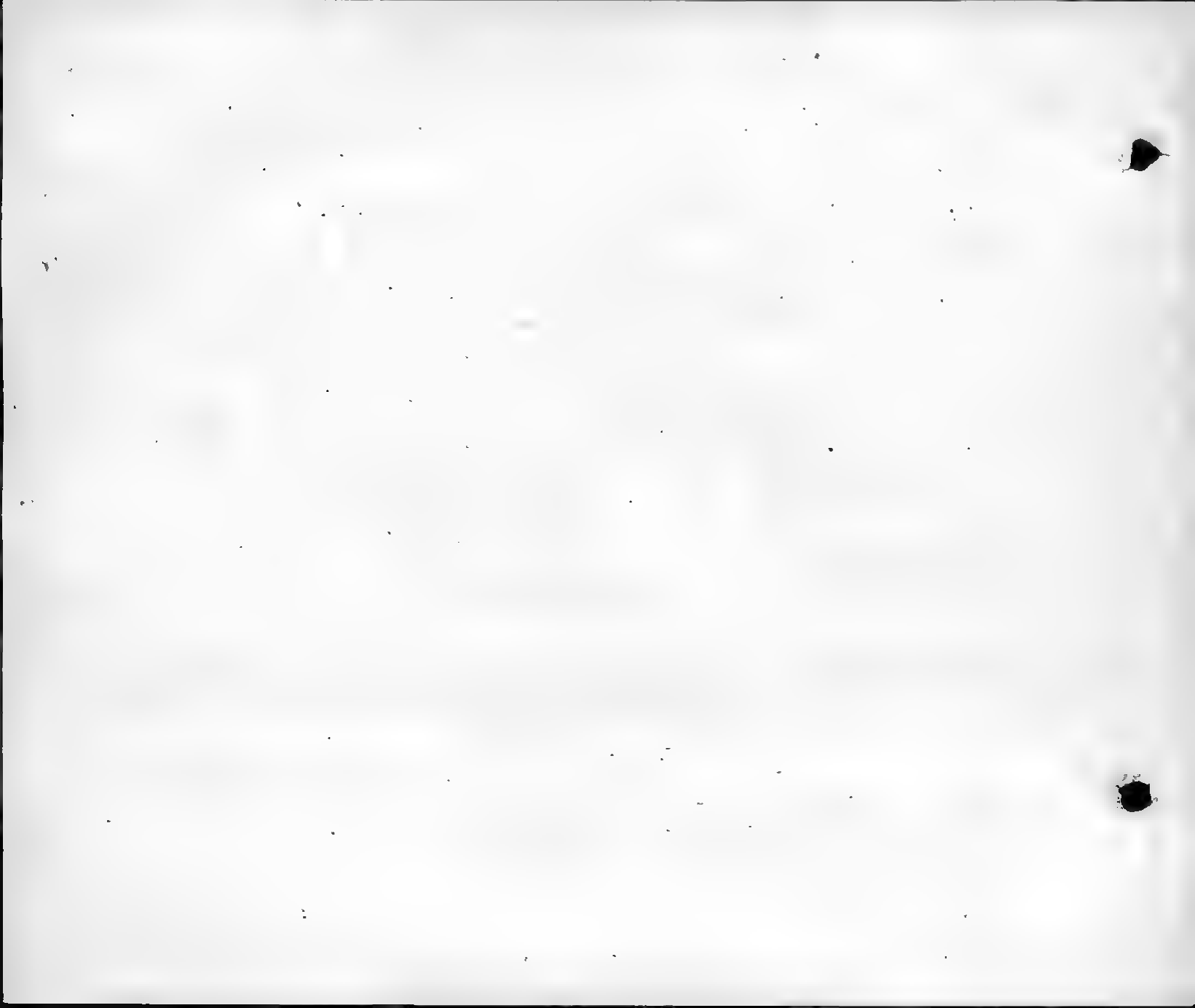
4475

M

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>44.75</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CHARLENE NURSING HOME</u>				d. STREET ADDRESS <u>CONESVILLE RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>F.</u> Last <u>HAVNER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-24-76</u>		9. AGE (in years last birthday) <u>85</u> yrs	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		INFORMANT <u>ELLA E. HAVNER</u>		Address <u>1272 KENNEDY AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Aneurysm</u> DUE TO <u>Generalized Atherosclerosis</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour o m p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14, 1957</u> to <u>April 20, 1961</u> , that I last saw the deceased alive on <u>April 15, 1961</u> , and that death occurred at <u>114 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John D. Rogers</u> M.D.				DATE SIGNED <u>April 20, 1961</u>			
PHYSICIAN'S NAME (Type) <u>John D. Rogers</u>							
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-22-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BETHESDA, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Williams</u>				ADDRESS <u>1400 Chapin St NW</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4476

04468

PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Beltsville

c. LENGTH OF STAY IN 1b

2 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Veterans Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Beltsville

d. STREET ADDRESS

1101 Kicking Horse Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First Middle Last

Mary Elizabeth

Hawes

First Middle Last

Mary Elizabeth

Hawes

4. DATE OF DEATH

Month Day Year

April 27

1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

10-1-60

9. AGE (in years: IF UNDER 1 YEAR IF UNDER 24 HRS.)

last birthday Months Days Hours Min.

1 7 27

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul T. Hawes

14. MOTHER'S MAIDEN NAME

Elizabeth Bradley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

Parents - same as above

17. INFORMANT

Parents - same as above

Address

Parents - same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Myocardia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Atelectasis

Increased intracranial pressure 6 mos.

INTERVAL BETWEEN ONSET AND DEATH

24 hours

24 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Congenital Absence of 10th rib

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

No

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of page 2)

None

20c. TIME OF INJURY

Hour am pm

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

None

20f. (City or town)

None

(County)

None

(State)

None

21 I certify that (I) (this hospital) attended the deceased from Birth to Apr 27, 1961, that (I) (we) last saw the deceased alive on Apr 27, 1961, and that death occurred at 10:25 PM, from the causes and on the date stated above.

22a. SIGNATURE

John T. Ford

ATTENDING PHYS.

☒

MED. DIRECTOR

☐

STAFF PHYS.

☐

22b. DATE SIGNED

Apr 27

22c. PHYSICIAN'S NAME (Type)

John T. Ford

22d. ADDRESS

1015 Spring St. Silver Sp.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

5-1-61

23c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven

23d. LOCATION (City, town or county)

Wheaton Md

(State)

Md

24. FUNERAL DIRECTOR'S SIGNATURE

Timothy Hanlon

ADDRESS

3831 Heavens

25a. REC'D BY REGISTRAR

DATE MAY 5 '61

25b. REGISTRAR'S SIGNATURE

and 20th

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15/4
15M/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

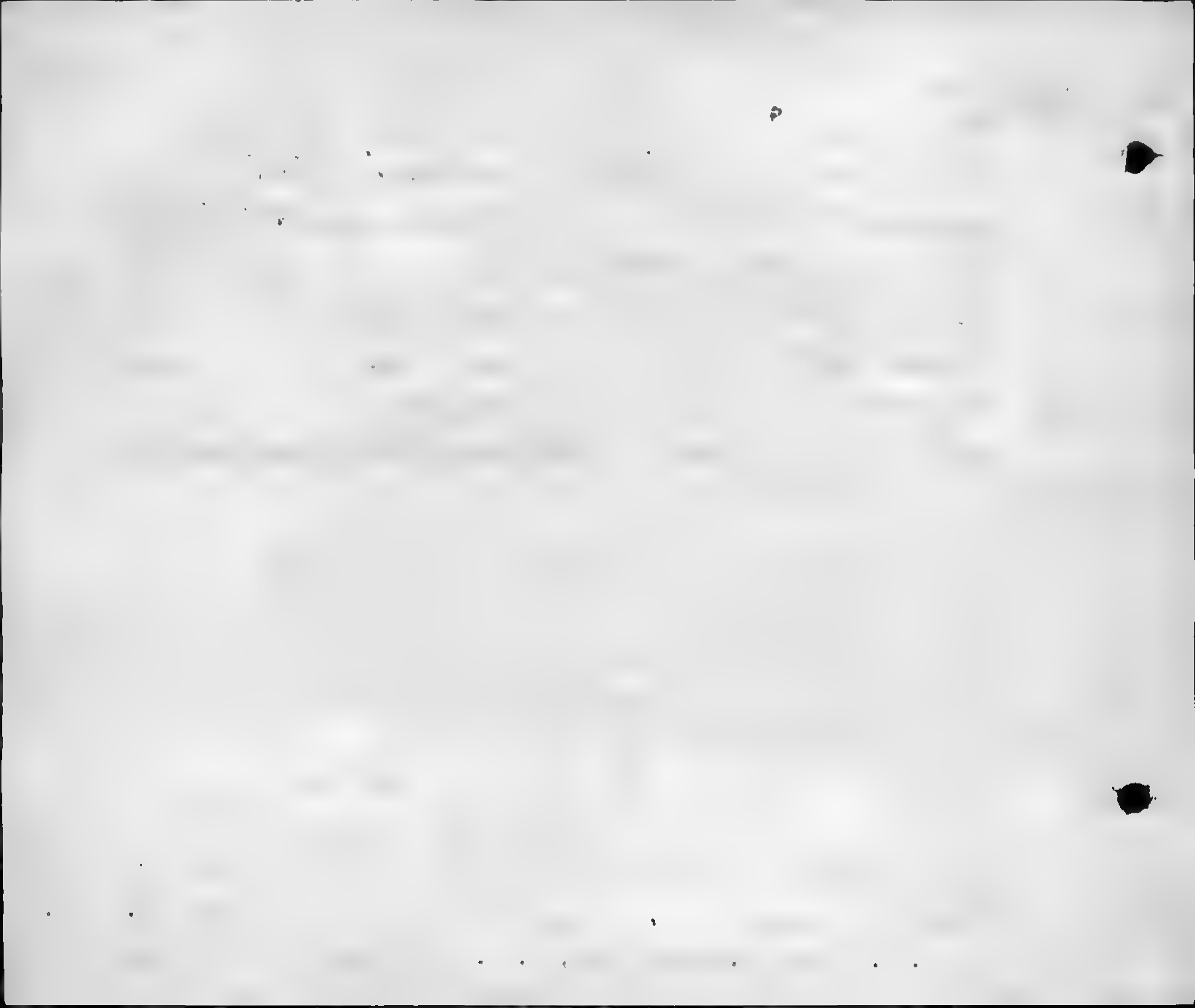
CERTIFICATE OF DEATH

04469

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY N 1b <u>13 da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3316 Runnymede Pl. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Annie</u> Middle <u>Hayes</u> Last		DATE OF DEATH <u>April 20</u> Year <u>1961</u>		9. AGE in years <u>88</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min _____			
5. SEX <u>F</u>		6. COLOR OR RACE <u>EW</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-13-73</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>			
13. FATHER'S NAME <u>Carson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Madelaine honey, same as above</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4802 pneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>? influenza</u> DUE TO _____ (c) <u>Senility + A.S.H.D.</u>							
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>4/7/61</u> to <u>4/20/61</u> that (I) (we) last saw the deceased alive on <u>4/20/61</u> and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Wadler</u> M.D.				22b. DATE SIGNED <u>4/20/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>				22d. ADDRESS <u>8218 W. Ave. B.T.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		24b. ADDRESS <u>Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>APR 24 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>				25c. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



4478
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04470

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 2 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				e. STREET ADDRESS 1 311 WATERFORD ROAD			
3. NAME OF DECEASED (Type or print) First VERONICA Middle M. Last HAYES				4. DATE OF DEATH Month 4 Day 27 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-25-04	
9. AGE (In years last birthday) 56 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK TYPIST		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME PATRICK J. MURPHY			
14. MOTHER'S MAIDEN NAME CATHERINE CAHALIN				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO 062-14-4551				17. INFORMANT Mrs. J. Leo Meyer Address 311 Waterford Road, Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix with 171X DUE TO metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Q 9 mos. DUE TO (c) Q 9 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Q 9 mos.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1952 to April 1961 , that (I) (we) last saw the deceased alive on 4-24-1961 , and that death occurred at 10:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE Bernard A. Dygman M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Bernard A. Dygman				22d. ADDRESS 217 University Dist E. S.D., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-1-61		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Collins ADDRESS 3821-14th St. N.W. Wash. D.C.				25. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE Charles L. Hanna	

(M)

(I)



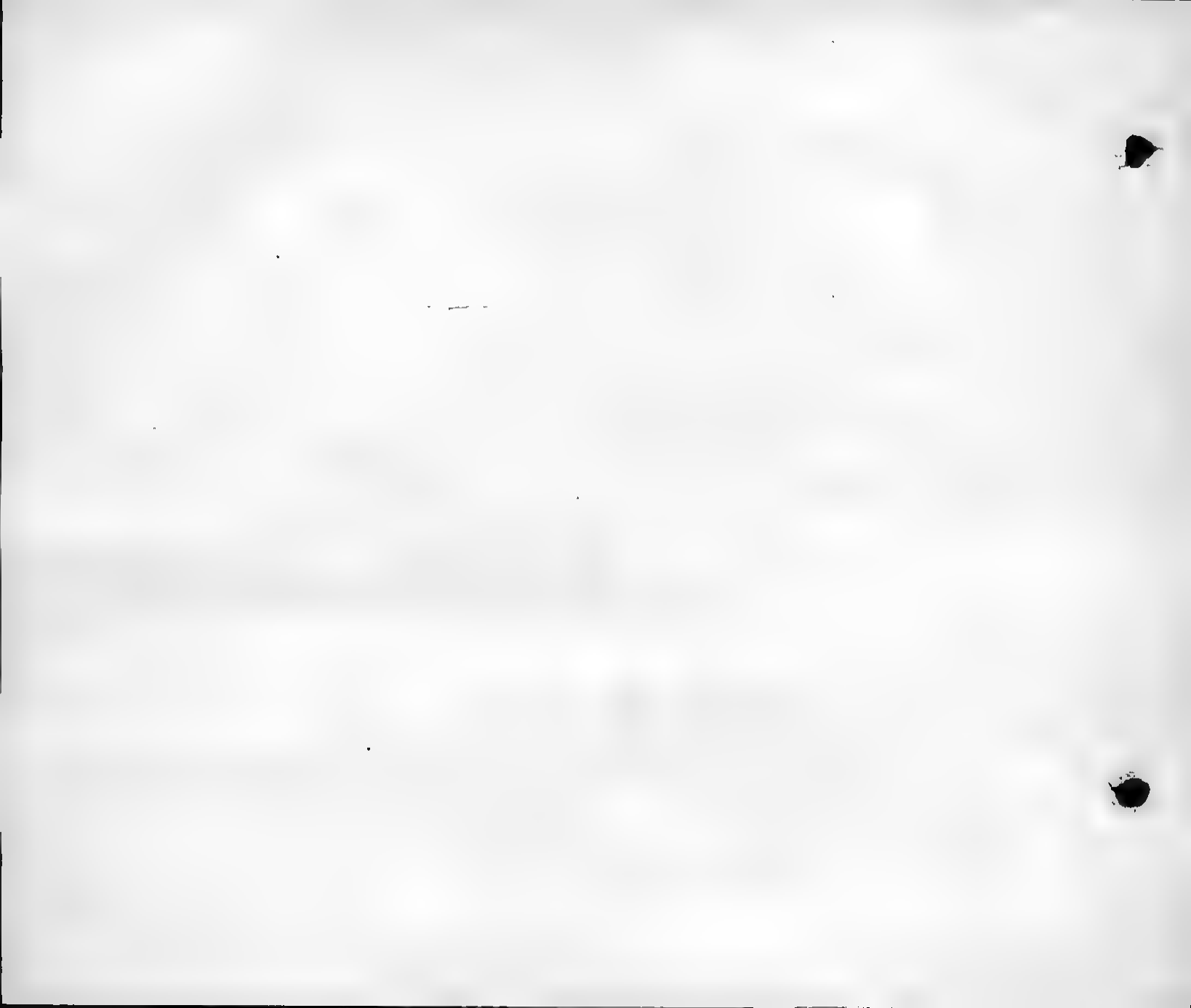
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4479

04471

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address, OR INSTITUTION)		d. STREET ADDRESS	
<u>CONGRESSIONAL MONROE SANITARIUM</u>		<u>4513 Harrison St. N.W.</u>	
3. NAME ON DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Ellen</u> Middle <u>R</u> Last <u>HEARD</u>		Month <u>April</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-17-1893</u>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>HOUSEWIFE</u>		<u>U.S.A. - DC</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>ALEXANDER A. PAURET</u>		<u>Elizabeth DOLEMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
<u>No</u>		<u>4513 Harrison St. N.W.</u>	
17. INFORMANT		Address	
<u>Mrs. Lucie E. Raymond</u>		<u>Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARteriosclerotic CARDIOVASCULAR DISEASE</u> <u>422.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1960</u> to <u>April 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 24, 1961</u> , and that death occurred at <u>8:41 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Sarah E. Glover</u>		22b. DATE SIGNED <u>April 28, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>		22d. ADDRESS <u>10128 CEDAR LANE Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Burial</u>		<u>5/1/61</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Cedar Hill Cem.</u>		<u>Switzland Pk Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
<u>Henry Shaw Funeral Home</u>		DATE <u>MAY 1 '61</u>	
ADDRESS <u>3703 Wisconsin Ave. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1
4480
4472
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>KENSINGTON</u> d. STREET ADDRESS <u>13922 DUNNELL LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES HOFFMANN HELMS</u>		4. DATE OF DEATH <u>APRIL 1 1961</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/10/91</u>		9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>21</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED (U.S. GOV'T.)</u>		12. KIND OF BUSINESS OR INDUSTRY <u>ASS'T. DEPUTY D.A. NACA (55 yrs.)</u>		13. BIRTHPLACE (Country & State, or foreign country) <u>BROOKLYN, N.Y.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>GEORGE HELMS</u>				16. MOTHER'S MAIDEN NAME <u>LOUISE HOFFMANN</u>			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				18. SOCIAL SECURITY NO. <u>Yes-Unknown</u>			
19. INFORMATION Address <u>MRS. BELLE K. HELMS (WIFE)</u>							
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCT.</u>							
420.1 DUE TO (b) <u>Arterio sclerosis, coronary Arteries</u>							
DUE TO (c) <u>Myocardial infarction</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>Septic ulcer, trochanteric healing</u>							
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>No</u>							
22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>No</u>							
23. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (I) (this hospital) attended the deceased from <u>Feb. 28, 1961</u> to <u>Apr. 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 1, 1961</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
28. SIGNATURE <u>Robert G. Tayler</u>		29. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		30. DATE SIGNED <u>Apr 2, 1961</u>		31. PHYSICIAN'S NAME (Type) <u>Robert G. Tayler</u>	
32. ADDRESS <u>Washington Clinic, Washington, D.C.</u>							
33. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		34. DATE THEREOF <u>4/4/61</u>		35. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		36. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
37. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		38. ADDRESS <u>Bethesda, Maryland</u>		39. REC'D BY REGISTRAR <u>Charles S. Kline</u>		40. REGISTRAR'S SIGNATURE	
DATE <u>APR 5 '61</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

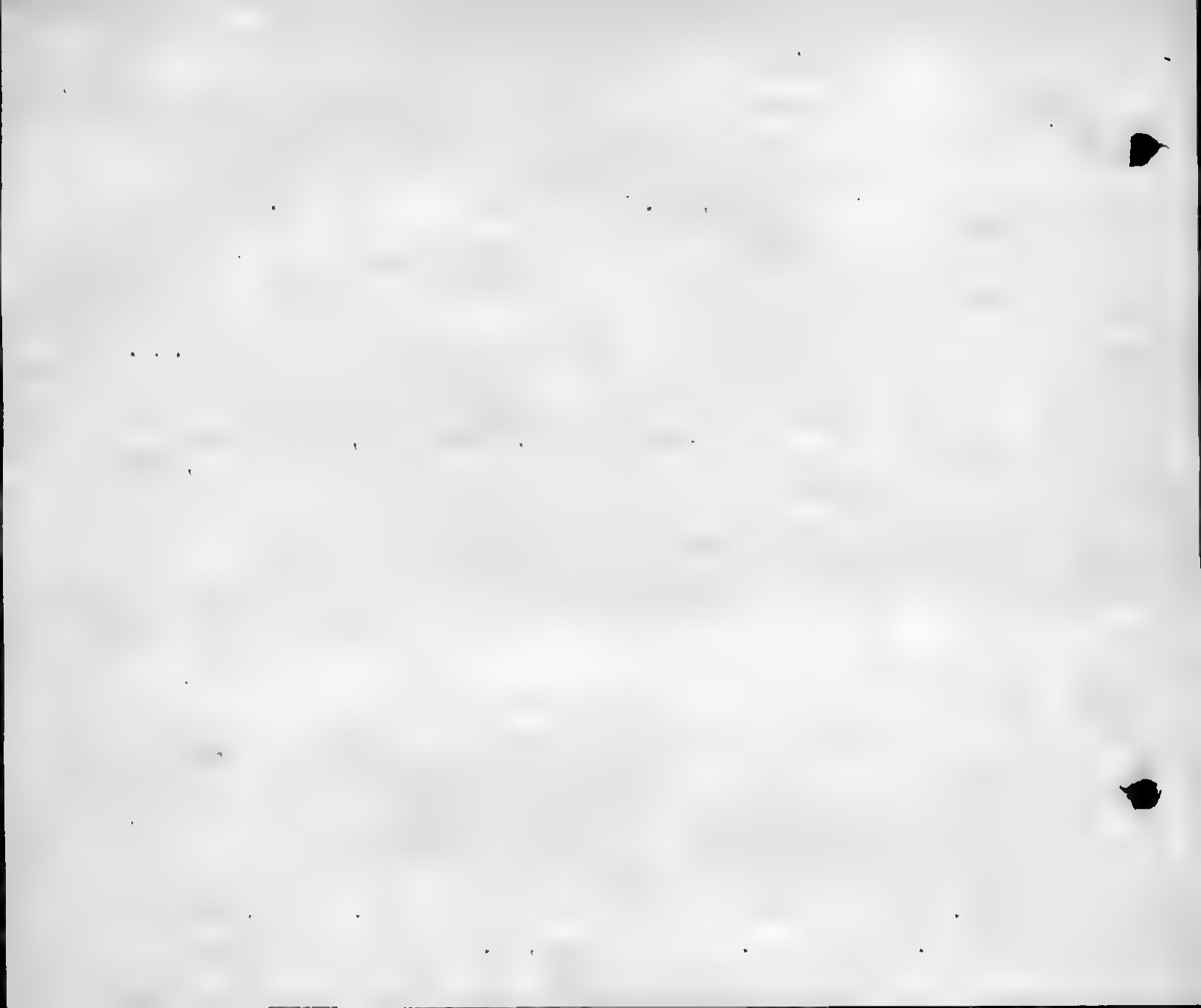
CERTIFICATE OF DEATH

4481

04473

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN <u>Since June 1960</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street address) <u>8207 GRUBB ROAD, Apt. 104</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>8207 GRUBB ROAD, Apt. 104</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE KUMPEL HERBERT</u>		4. DATE OF DEATH Month Day Year <u>APRIL 19 19 61</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/7/10</u>		9. AGE (In years last birthday) <u>51 yrs.</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mins. _____											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switchboard Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Suburban Hospital</u>				11. BIRTHPLACE County & State or foreign country <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>EDGAR CARROW</u>				14. MOTHER'S MAIDEN NAME <u>NELLIE BURTON</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>221-10-6167</u>				17. INFORMANT Address <u>Mrs. Robert Hanna, 2533 Ross Road</u> <u>Silver Spring, Maryland</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town		County		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 19 61</u> to <u>April 19 61</u> that (I) (we) last saw the deceased alive on <u>4/18 1961</u> and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.												22a. SIGNATURE <u>Sanford J. Randall</u> M.D.		22b. ADDRESS <u>70. 8329 Grubb Rd. S.S. Md.</u>		22c. PHYSICIAN'S NAME (Type) <u>SANFORD J. RANDALL</u>		22d. DATE <u>4/19/61</u>		22e. SIGNATURE <u>Charles S. Kraus</u>		22f. DATE <u>APR 21 '61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>				23b. DATE THEREOF <u>4/19/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>HICKORY GROVE CEMETERY</u>				23d. LOCATION (City, town or county) <u>ST. GEORGES, DELAWARE</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>				25a. REC'D BY REGISTRAR <u>SILVER SPRING, MD.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>				25c. DATE <u>APR 21 '61</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05792

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence Robert Howard</u>		d. STREET ADDRESS <u>1 Fields Road</u>	
5. SEX <u>male</u>		4. DATE OF DEATH <u>Apr 30 1961</u>	
6. COLOR OR RACE <u>white</u>		8. DATE OF BIRTH <u>3-17-32</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years, last birthday) <u>29</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence H. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Virgie Rickitts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Transsection of spinal cord</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple skull fractures</u>			
(c) <u>Struck by car</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian - crossing highway & struck by auto</u>			
20c. TIME OF INJURY - Month, Day, Year <u>11:30 p.m. 4-29-61</u>			
20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. Route 240, N. Rockville Montg md</u>			
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <u>Frank J. Broschart</u> M.D.			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-30-61</u>			
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Neelsville, Mont. Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Lynn Wheeler Fun Home</u>		24a. REC'D BY REGISTRAR <u>MAY 2 '61</u>	
ADDRESS <u>1331 E. Montgomery Ave. Rockville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Knecht</u>	

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
FURNAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

4483
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04474

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN <u>MD</u> <u>13 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R70 #3</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (rural)</u> d. STREET ADDRESS <u>R70 #3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virgil Summer Hughes</u> First Middle Last 4. DATE OF DEATH <u>Apr 1 1961</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>wh</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-10-94</u> 9. AGE (in years, last birthday) <u>66</u> yrs. If UNDER 1 YEAR: Months Days If UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Mich.</u> 11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Singleton Hughes</u> 14. MOTHER'S MAIDEN NAME <u>Anaeth Bird</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Bertha Hughes (wife)</u> Address <u>Stim 2</u>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>no</u> DUE TO (c) <u>no</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschew</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschew</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-1-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 22b. DATE THEREOF <u>4/4/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Wt. Auburn.</u> 22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>		23. FUNERAL DIRECTOR <u>Robert L. Swindle</u> ADDRESS <u>Rockville, Md.</u> 24a. REC'D BY REGISTRAR <u>APR 7 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

4484

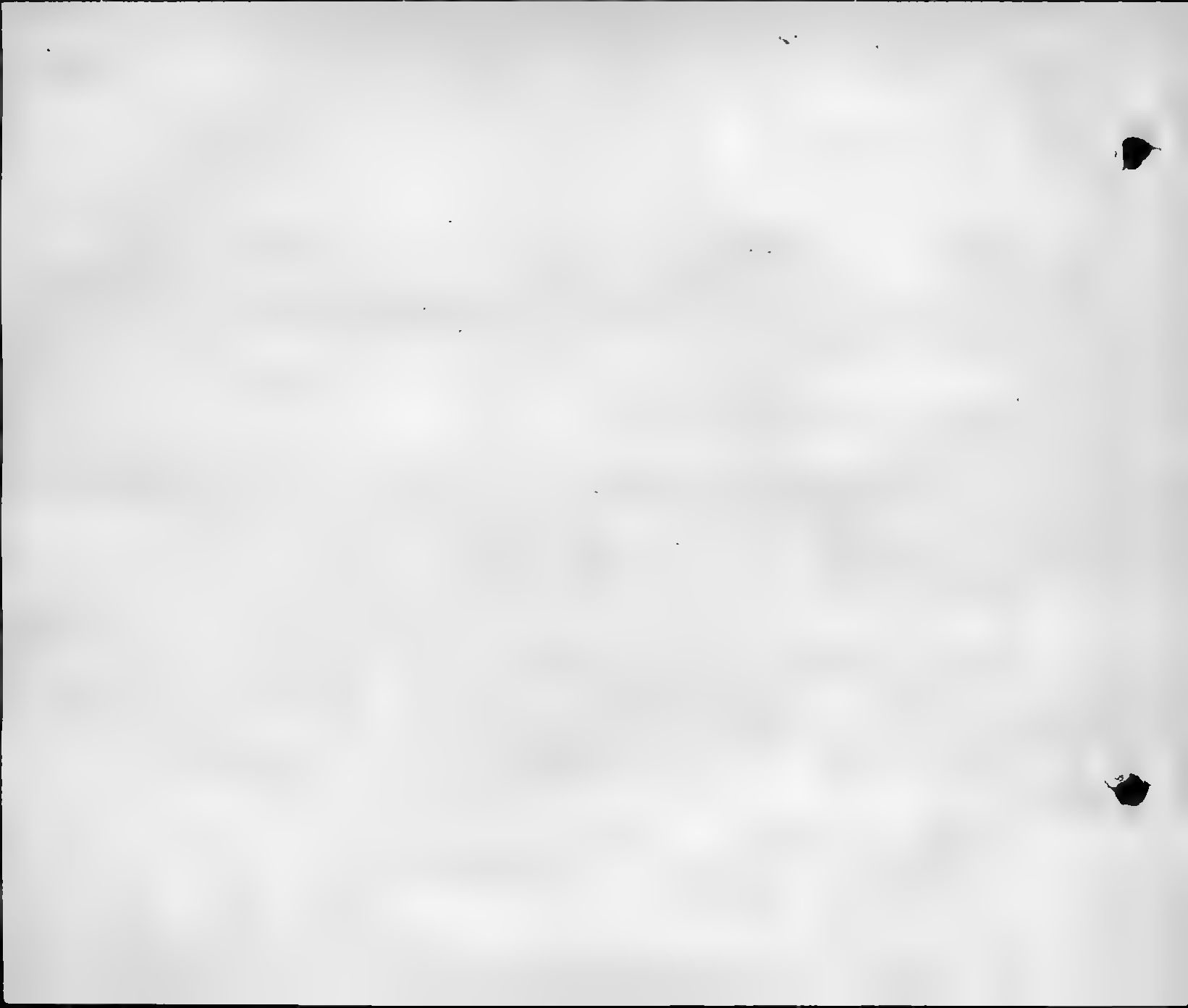
4484

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04475

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Germanstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>	
c. LENGTH OF STAY IN lb <u>3 yrs</u>		d. STREET ADDRESS <u>Water Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachael</u>	4. DATE OF DEATH <u>April 23 1961</u>	5. SEX <u>Female</u>	
6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-1904</u>	
9. AGE (In years; last birthday) <u>57 yrs</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	13. FATHER'S NAME <u>Walter Smith</u>	14. MOTHER'S MAIDEN NAME <u>Ediz. Ring</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>420.1</u>	17. INFORMANT <u>Robert Lee Hunt - Stone 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bioschat</u>	CHIEF MEDICAL EXAMINER		DATE SIGNED <u>4-23-61</u>
EXAMINER'S NAME (Type) <u>FRANK J. Bioschat</u>	DEPUTY MEDICAL EXAMINER <u>Arthur S. Kline</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/26/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	22d. LOCATION (City, town, or country) (State) <u>Beallsville MD</u>
23. FUNERAL DIRECTOR <u>William C. Hillen, Beallsville MD</u>	24a. REC'D BY REGISTRAR <u>APR 28 '61</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4485

CERTIFICATE OF DEATH

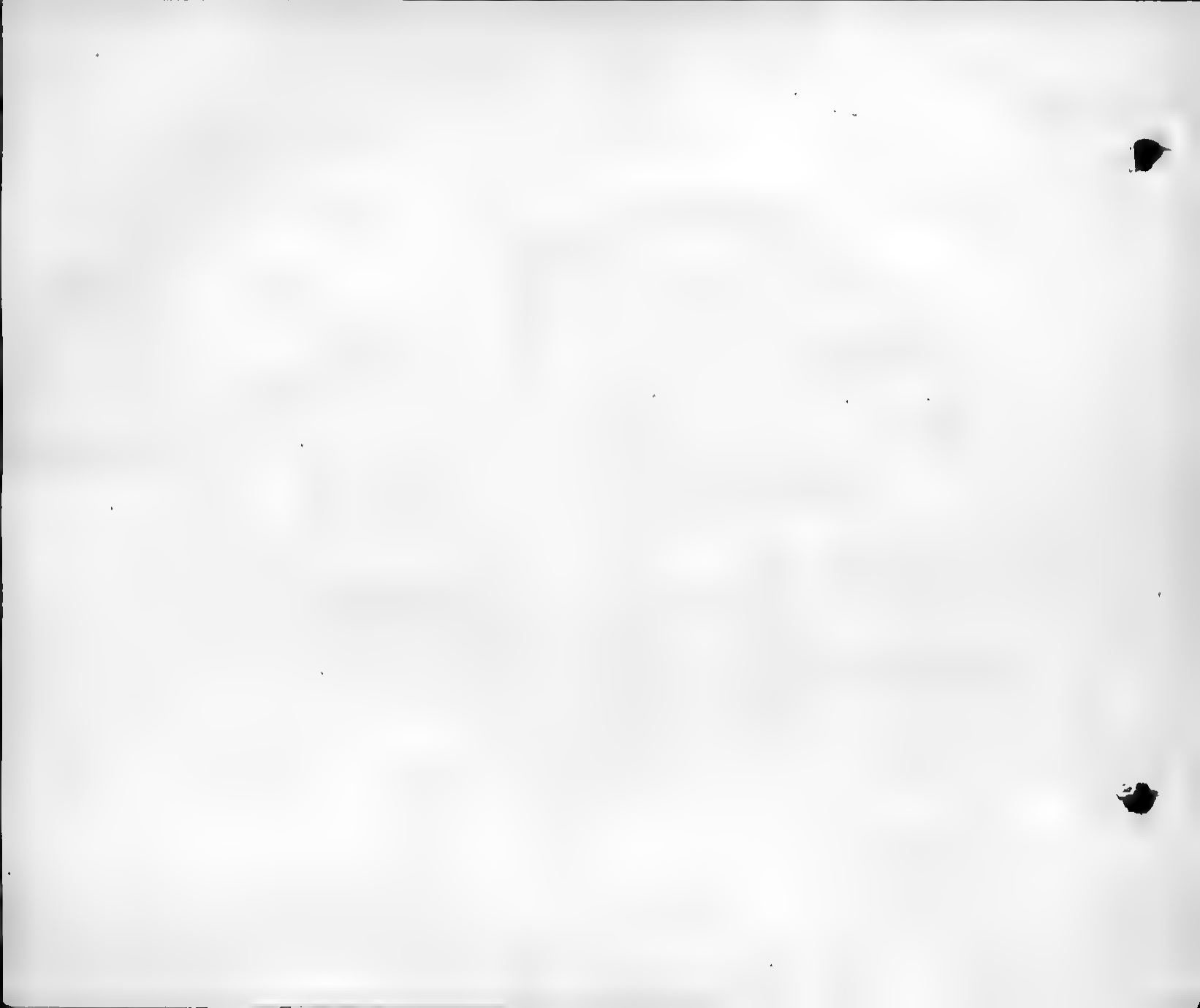
Reg. Dist. No.

04476

1. PLACE OF DEATH a. COUNTY <u>MONTG.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SSIG.</u>		c. LENGTH OF STAY IN 1b <u>-</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARILEA NURSING HOME</u>		d. STREET ADDRESS <u>11852 HUGGINS DR</u>	
3. NAME OF DECEASED (Type or print) First <u>CLAIRE</u> Middle <u>-</u> Last <u>ISKOWITZ</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/1901</u>
9. AGE (In years last birthday) <u>59</u> yts		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y. CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK STEGMAN (Dec.)</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE HERSHBERG (Dec.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROBERT H. ISKOWITZ</u>		Address <u>11852 Huggins Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with</u> DUE TO <u>110X</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>widely spread metastases</u> DUE TO <u>1 yr.</u> (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 13, 1961</u> to <u>April 19, 1961</u> , that I last saw the deceased alive on <u>April 13, 1961</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>John P. Rogers, M.D.</u>		ADDRESS (Street, city or town, state) <u>1919 Seminary Rd Silver Spring, Md. 20906</u>	
DATE SIGNED <u>Apr 19 1961</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>		ADDRESS <u>4217-9 Ave</u>	
24a. REC'D BY REGISTRAR <u>PR 12 61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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15M 9/59

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04477

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2+ yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stetha Woodland, 1000 Silver Spring Rd</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X</u>	
f. STREET ADDRESS <u>6700 Pine Branch Rd NW</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>ORCHARD</u> Last <u>ISRAEL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1872</u>
9. AGE (Years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Nashville, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John Orchard</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Mcivorin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>William J. Coleman (Same as #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Hypostatic pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Cerebral Thrombosis</u> DUE TO <u>Generalized arteriosclerosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 wk</u> <u>Many years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>July</u> Day <u>12</u> Year <u>1958</u> Hour <u>a.m.</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>July 12, 1958</u> to <u>4/26, 1961</u> , that (1) (we) last saw the deceased alive on <u>4/26, 1961</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>James R. Coleman MD</u> M.D.		22b. DATE SIGNED <u>4/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d. ADDRESS <u>733 Aligo Ave. Silver Spring, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 29, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Wactor, 254 Carroll St NW DC</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4487

CERTIFICATE OF DEATH

04478

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>9 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le. Deau Gardens Nursing Home</u>				d. STREET ADDRESS <u>10419 HUNTLEY AVENUE</u>			
3. NAME OF DECEASED (Type or print) <u>Myrtle L. German</u>				4. DATE OF DEATH <u>April 9th 1961</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29th 1892</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Sebastian</u>			
14. MOTHER'S MAIDEN NAME <u>MARY Adamson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16 SOCIAL SECURITY NO. <u>—</u>				17 INFORMANT <u>Laird German</u> Address <u>(10419 Huntley Ave Silver Sp. Md.)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLISM → LEFT HEMIPLEGIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARITMICAL FIBRILLATION</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 WEEKS</u> <u>3-4 YRS</u> <u>SEVERAL YRS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JAN 22, 1960</u> , to <u>APRIL 9, 1961</u> , that I last saw the deceased alive on <u>APRIL 9, 1961</u> , and that death occurred at <u>11:54 A.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 Georgia Ave.</u>				ADDRESS (Street, city or town, state) <u>SILVER SPRING, MARYLAND</u>			
DATE SIGNED <u>APRIL 9, 1961</u>				PHYSICIAN'S NAME (Type) <u>JAMES A ROBERTS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		22b. DATE THEREOF <u>4-13-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Switband Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas B Handon</u> ADDRESS <u>3831-GA. Ave N, W</u>				24a. REC'D BY REGISTRAR <u>DATE APR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

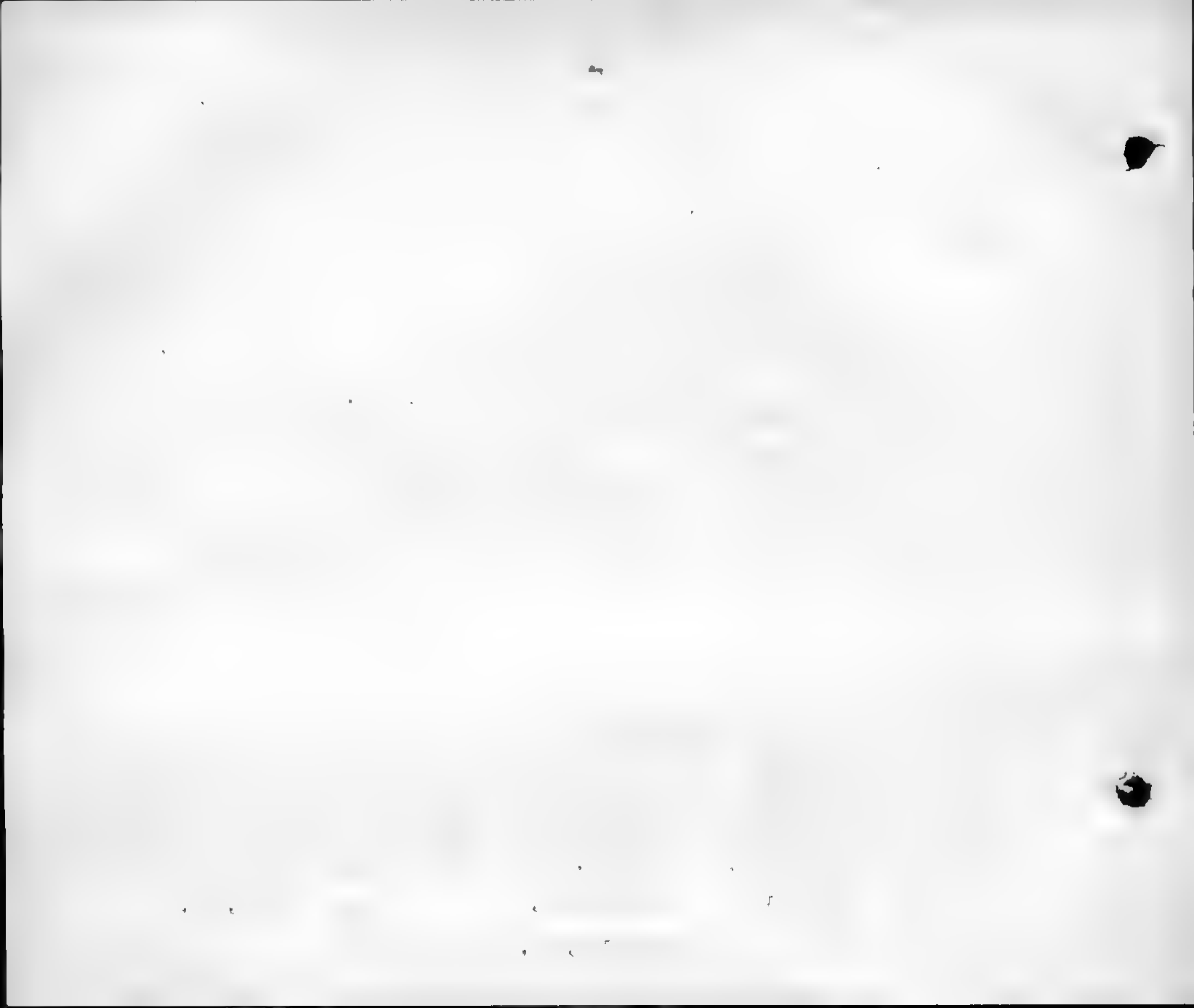
VR A15 (4)
15M 9/59

4483

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

0447J

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 22 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MABEL Middle LAVINIA Last JOHNSON		4. DATE OF DEATH Month APRIL Day 26 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1900
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SAMUEL T. HILL		14. MOTHER'S MAIDEN NAME MARY E. KING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Pulmonary Embolus, Thrombosis, & Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic ulcer duodenum. Cirrhosis of Liver INTERVAL BETWEEN ONSET AND DEATH 5 min yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 61 to 4/26 19 61 that (I) (we) last saw the deceased alive on 4/26 19 61, and that death occurred at 6:00 PM, from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Ligon		22b. DATE SIGNED 4/27/61	
22c. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M.D.		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 4/29/61	
23c. NAME OF CEMETERY OR CREMATORY Sandy Spring,		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swinton		25a. REC'D BY REGISTRAR DATE MAY 2 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Friend			



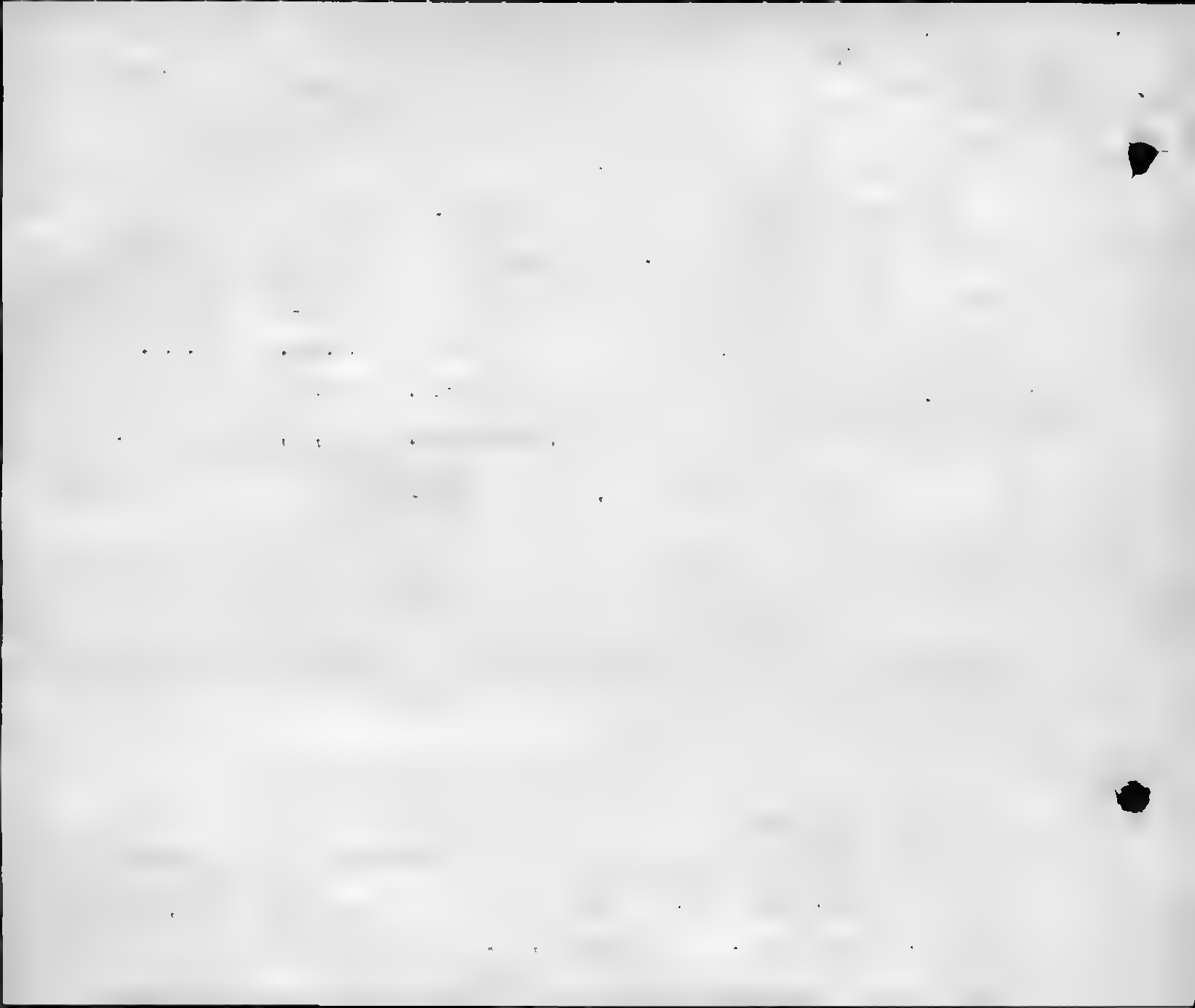
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04480											
1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE FLORIDA b. COUNTY ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN IL 3 weeks				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ORLANDO			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL				d. STREET ADDRESS 318 W. HAZEL AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROSE W. KARR				4. DATE OF DEATH April 13 1961				5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 1/13/70				9. AGE (In years last birthday) 91 yrs				10. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State or foreign country) SILVER SPRING, MD.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN C. WILSON				14. MOTHER'S MAIDEN NAME SILVIA PENDLETON SELINA PENDLETON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE				17. INFORMANT Mr. Lawrence Z. Wilson, 10, 102 Gates Ave. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. CAUSE WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA BLADDER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10011 GEORGIA AVE SILVER SPRING, MD.			
20f. City or town SILVER SPRING				20g. (County) MONTGOMERY COUNTY, MARYLAND				20h. (State) MARYLAND			
21. I certify that (I) (this hospital) attended the deceased from 2/15 19 61 to 4/12 19 61 , that (I) (we) last saw the deceased alive on 4/11 19 61 , and that death occurred at 12:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE Henry W. Stout MD 22b. DATE SIGNED 4/13/61											
22c. PHYSICIAN'S NAME (Type) H.W. STOUT MD											
22d. ADDRESS 10011 GEORGIA AVE SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL											
23b. DATE THEREOF 4/15/61											
23c. NAME OF CEMETERY OR CREMATORY GRACE EPISCOPAL CHURCH CEMETERY											
23d. LOCATION (City, town or county) MONTGOMERY COUNTY, MARYLAND											
23e. REC'D BY REGISTRAR APR 19 '61											
23f. REGISTRAR'S SIGNATURE Arthur S. Kraus											
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska											



VS. A15ME
5M 7/59

Address:

Washington Jan & Hospital Records

INTERVAL BETWEEN
ONSET AND DEATH

2000

[illegible]

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

10. *Journal of the American Medical Association*, 273, 1994, 1033-1038.

NAME: _____

Journal of Management Inquiry 16(4)

Parameter	Reference		Present study	
	1	2	3	4
1. α	0.0000	0.0000	0.0000	0.0000
2. β	0.0000	0.0000	0.0000	0.0000
3. γ	0.0000	0.0000	0.0000	0.0000
4. δ	0.0000	0.0000	0.0000	0.0000
5. ϵ	0.0000	0.0000	0.0000	0.0000
6. ζ	0.0000	0.0000	0.0000	0.0000
7. η	0.0000	0.0000	0.0000	0.0000
8. θ	0.0000	0.0000	0.0000	0.0000
9. ϕ	0.0000	0.0000	0.0000	0.0000
10. ψ	0.0000	0.0000	0.0000	0.0000
11. χ	0.0000	0.0000	0.0000	0.0000
12. ω	0.0000	0.0000	0.0000	0.0000
13. ν	0.0000	0.0000	0.0000	0.0000
14. μ	0.0000	0.0000	0.0000	0.0000
15. λ	0.0000	0.0000	0.0000	0.0000
16. κ	0.0000	0.0000	0.0000	0.0000
17. ι	0.0000	0.0000	0.0000	0.0000
18. σ	0.0000	0.0000	0.0000	0.0000
19. τ	0.0000	0.0000	0.0000	0.0000
20. ρ	0.0000	0.0000	0.0000	0.0000
21. ϕ	0.0000	0.0000	0.0000	0.0000
22. χ	0.0000	0.0000	0.0000	0.0000
23. ω	0.0000	0.0000	0.0000	0.0000
24. ν	0.0000	0.0000	0.0000	0.0000
25. μ	0.0000	0.0000	0.0000	0.0000
26. λ	0.0000	0.0000	0.0000	0.0000
27. κ	0.0000	0.0000	0.0000	0.0000
28. ι	0.0000	0.0000	0.0000	0.0000
29. σ	0.0000	0.0000	0.0000	0.0000
30. τ	0.0000	0.0000	0.0000	0.0000
31. ρ	0.0000	0.0000	0.0000	0.0000
32. ϕ	0.0000	0.0000	0.0000	0.0000
33. χ	0.0000	0.0000	0.0000	0.0000
34. ω	0.0000	0.0000	0.0000	0.0000
35. ν	0.0000	0.0000	0.0000	0.0000
36. μ	0.0000	0.0000	0.0000	0.0000
37. λ	0.0000	0.0000	0.0000	0.0000
38. κ	0.0000	0.0000	0.0000	0.0000
39. ι	0.0000	0.0000	0.0000	0.0000
40. σ	0.0000	0.0000	0.0000	0.0000
41. τ	0.0000	0.0000	0.0000	0.0000
42. ρ	0.0000	0.0000	0.0000	0.0000
43. ϕ	0.0000	0.0000	0.0000	0.0000
44. χ	0.0000	0.0000	0.0000	0.0000
45. ω	0.0000	0.0000	0.0000	0.0000
46. ν	0.0000	0.0000	0.0000	0.0000
47. μ	0.0000	0.0000	0.0000	0.0000
48. λ	0.0000	0.0000	0.0000	0.0000
49. κ	0.0000	0.0000	0.0000	0.0000
50. ι	0.0000	0.0000	0.0000	0.0000
51. σ	0.0000	0.0000	0.0000	0.0000
52. τ	0.0000	0.0000	0.0000	0.0000
53. ρ	0.0000	0.0000	0.0000	0.0000
54. ϕ	0.0000	0.0000	0.0000	0.0000
55. χ	0.0000	0.0000	0.0000	0.0000
56. ω	0.0000	0.0000	0.0000	0.0000
57. ν	0.0000	0.0000	0.0000	0.0000
58. μ	0			

Q) 19. WAS AUTOP
PERFORMED

YES ☐ NO ☐

YES ☐ NO ☐

[illegible]

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04482

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7009 Maple Ave

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. STREET ADDRESS 7009 Maple Ave

3. NAME OF DECEASED (Type or print) Earl Foster Kelley
4. DATE OF DEATH Apr 22 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 7-29-86 9. AGE (In years, last birthday) 74 yrs. 10. AGE (In years, last birthday) 74 yrs. 11. BIRTHPLACE (State or foreign country) Ill. Iowa 12. CITIZEN OF WHAT COUNTRY? U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. employee (retired) Pub. Roads
10b. KIND OF BUSINESS OR INDUSTRY Gov. employee (retired) Pub. Roads
13. FATHER'S NAME Thomas Kelley 14. MOTHER'S MAIDEN NAME (Unknown) Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Robert Kelley-son-same 2d Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

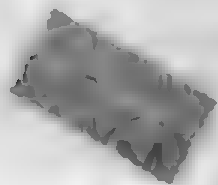
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschait M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J. Broschait ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 4-22-61
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 4/24/61 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 22d. LOCATION (City, town, or country) Suitland, Maryland
23. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Maryland 24a. REC'D BY REG STRAR Arthur S. Hines 24b. REGISTRAR'S SIGNATURE

INTERVAL BETWEEN ONSET AND DEATH
Found dead on bed room floor at home



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

44483

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge
c. LENGTH OF STAY IN 1b 2-2-61
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY Monty
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Spencerville
d. STREET ADDRESS 1 Batson Rd

3. NAME OF DECEASED (Type or print) Thelma Juanita Kelly
First Middle Last
4. DATE OF DEATH Apr 12 1961 Month Day Year
5. SEX Female 6. COLOR OR RACE Col 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 2-20-61 9. AGE (In years, last birthday) 1 yrs. 1 month 20 days 12 hours 0 min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) md 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Norman E. Kelly Jr 14. MOTHER'S MAIDEN NAME Maryann Watkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Norman E. Kelly Jr. (Father) Address Stue 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
a. IMMEDIATE CAUSE (a) Asphyxia
b. +75X DUE TO Upper Respiratory Infection
c. None DUE TO None
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NOT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ at work ☐ Not While ☐ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None 20f. (City or town) Spencerville (County) Monty (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 4-12-61
Address (Street, city, town, or county) Spencerville, Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/15/61 22c. NAME OF CEMETERY OR CREMATORY Round Oak 22d. LOCATION (City, town, or country) Spencerville, Md (State) MD

23. FUNERAL DIRECTOR Robert L. Snower ADDRESS Rockville, Md 24a. REC'D BY REGISTRAR APR 20 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hume



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

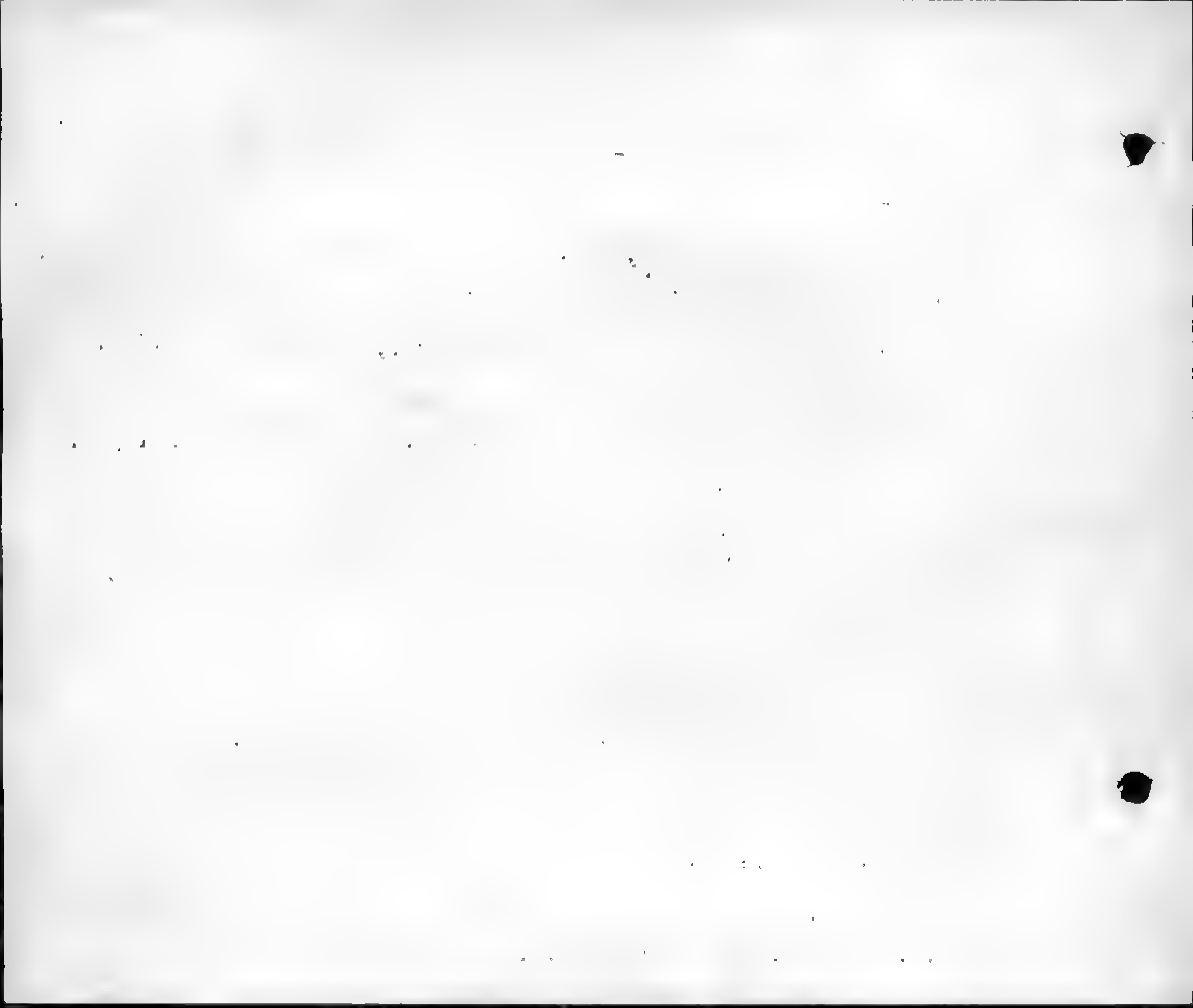
Reg. Dist. No.

4493

04484

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		c. LENGTH OF STAY IN 1b --	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		e. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Florence Middle Kincheloe Last		4. DATE OF DEATH Month April Day 25 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/28/1873
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Nursing Home		10b. KIND OF BUSINESS OR INDUSTRY Adams Co., Illinois	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Michael		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
INFORMANT Florence L. Atkinson-Barnesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Renal Arteriosclerotic Disease with Uremia DUE TO (c) Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 3 days 7 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. Hemiparesis due to old C. V. A.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1958 , to 25 April 1961 , that I last saw the deceased alive on 24 April 1961 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		DATE SIGNED 25 April 61	
PHYSICIAN'S NAME (Type) Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville Maryland	
22a. BURIAL, CREMATON, REMOVAL (Specify) burial		22b. DATE THEREOF 4/28/61	
22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE APR 27 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
4494
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04485

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Washington, DC</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4210-38th ST</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanatorium</i>		d. STREET ADDRESS <i>47X-3</i>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>MAY</i> Last <i>King</i>		4. DATE OF DEATH Month <i>April</i> Day <i>22</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>22 APRIL 1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	9. AGE (In years last birthday) <i>86</i> yrs
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Gregory Chanes</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Normile</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Cardiovascular Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5-5</i> 19 <i>60</i> to <i>4-22</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>4-22</i> 19 <i>61</i> , and that death occurred at <i>3 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>James W. Egan</i> M.D.		22b. DATE SIGNED <i>4-22-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES W. EGAN</i>		22d. ADDRESS <i>7720 Wisconsin Ave. Bethesda Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>April 24, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Washington DC</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. Don. DeVol</i> ADDRESS <i>2224-Wis. Ave. N.W. DC</i>		25. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04486

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) 10,400 Colesville Rd.		d. STREET ADDRESS 10,400 Colesville Rd.	

3. NAME OF DECEASED (Type or print) ANGELA ELIZABETH KINSMAN		4. DATE OF DEATH Month April Day 23 Year 19 61	
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5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1874	9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife—own home	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Oliver Dorrance Kinsman	14. MOTHER'S MAIDEN NAME Emma Matilda Louisa Richardson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO None	17. INFORMANT Olive D. Kinsman 10400 Colesville Rd. SS, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular thrombosis		3 days
DUE TO (b) Generalized arteriosclerosis		30 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) cardio-vasc. disease		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I attended the deceased from 1952 , 19 to 22 April 19 61 , that I last saw the deceased alive on 22 April 19 61 , and that death occurred at 8 P. M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Ernest E. Harmon MD	ADDRESS (Street, city, or town, state) 9301 Silverville Rd DATE SIGNED
PHYSICIAN'S NAME (Type) ERNEST E. HARMON	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF April 25, 1961	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Montg. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Ziska		24a. REC'D BY REGISTRAR APR 25 '61	24b. REGISTRAR'S SIGNATURE Charles S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4496
CERTIFICATE OF DEATH

114487

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville Rural c. LENGTH OF STAY IN b. 5 Mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Matthews Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if last location; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6800-Bradgrove Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Emma Klingensmith		4. DATE OF DEATH Month 4 Day 17 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 18-1873	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 4 Days 17 Hours 17 M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 206-01-6495D	
11. BIRTHPLACE, County & State, or foreign country Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Levi Enfield		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT John Klingensmith, 6800-Bradgrove Circle Address Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 months 6 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 22 Aug. 1960 , to 17 April, 1961 , that (I) (we) last saw the deceased alive on 16 April 1961 , and that death occurred at 10AM , from the causes and on the date stated above			
22a. SIGNATURE Gordon M. Smith		22b. DATE SIGNED 17 April 61	
22c. PHYSICIAN'S NAME (Type) Gordon M. Smith		22d. ADDRESS Barnesville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/61	
23c. NAME OF CEMETERY OR CREMATORY Barnesville, Md		23d. LOCATION (City, town or county) (State) Greensburg, Pa	
24. FUNERAL DIRECTOR'S SIGNATURE William B. Hillow		25a. REC'D BY REGISTRAR DATE APR 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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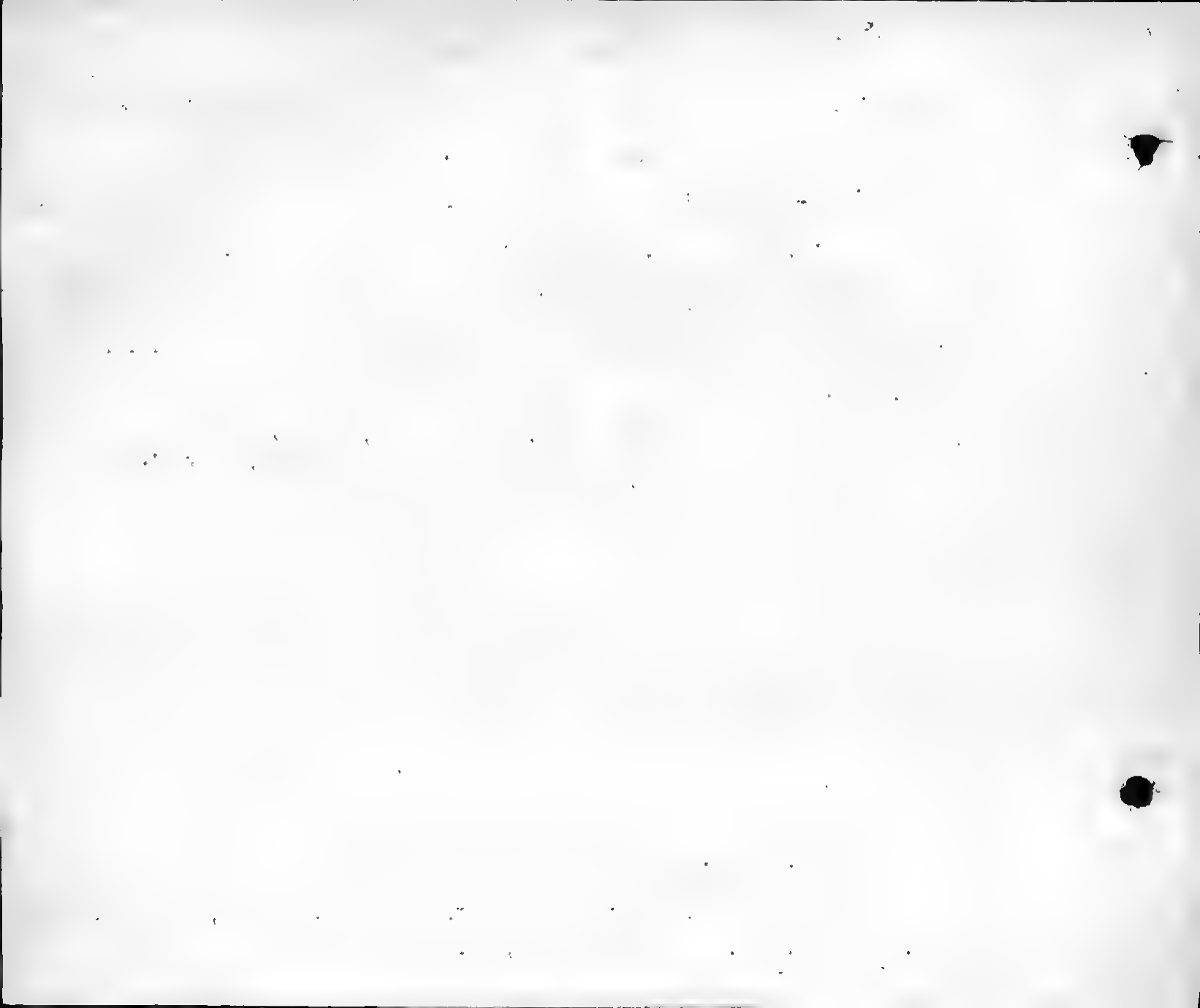
4497

CERTIFICATE OF DEATH

Reg. Dist. No.

04468

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 509 GILMORE DRIVE		d. STREET ADDRESS 1112 S. Potomac Street	
3. NAME OF DECEASED (Type or print) VESTA		4. DATE OF DEATH Month APRIL Day 26 Year 19 61	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/7/92	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OTTO G. KRETZER		14. MOTHER'S MAIDEN NAME unknown JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Miles Murphy, 509 Gilmore Drive Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Congestive failure of heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized atherosclerotic cardio-vascular disease DUE TO (c) 3-4 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 10, 19 61 to April 26, 19 61 that I last saw the deceased alive on 26 April 19 61 , and that death occurred at 4 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 9301 Colosville Rd. Silver Spring, Md. DATE SIGNED Ernest E. Harmon			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF 4/29/61			
22c. NAME OF CEMETERY OR CREMATORY SHEPARDSTOWN CEMETERY			
22d. LOCATION (City, town, or county) (State) SHEPARDSTOWN, WEST VIRGINIA			
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Samuel A. Pumphrey			
24a. REC'D BY REGISTRAR DATE APR 27 '61			
24b. REGISTRAR'S SIGNATURE William L. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4498

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04484

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 32 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 153 Reed Avenue			
3. NAME OF DECEASED (Type or print) Peter First Michael Middle Kocubinski Last				4. DATE OF DEATH April Month 14, Day 19 Year 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1930	
9. AGE (In years last birthday) 31 yrs		IF UNDER 1 YEAR Months 31 Days 31 Hours 31 Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic - Aircraft				10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stephen Kocubinski				14. MOTHER'S MAIDEN NAME Helen Jankiewicz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES Korea Korea				16. SOCIAL SECURITY NO. 045-000-0000			
17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL METASTASES							
DUE TO CHONDROSARCOMA OF NASOPHARYNX							
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 13, 1961 to April 14, 1961 that (I) (we) last saw the deceased alive on April 14, 1961 , and that death occurred at 5:42 PM from the causes and on the date stated above							
22a. SIGNATURE Haskins K. Kashima M.D.				22b. DATE 15 APRIL 1961			
22c. PHYSICIAN'S NAME (Type) HASKINS - K KASHIMA				22d. ADDRESS National Institutes of Health The Clinical Center, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/18/1961		23c. NAME OF CEMETERY OR CREMATORY ST. HEDWIG'S CEMETERY		23d. LOCAT ON (City, town, or county) (State) EWING TOWNSHIP, NEW JERSEY	
24. FUNERAL DIRECTOR'S SIGNATURE Thosong S. Funeral Home				25a. REC'D BY REGISTRAR 1300-N. ST. N.W. DATE PR 17 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kama							

15 APR 1961

CHORDESMONTE OF NASOPHARYNX
INT-ASGAMING INETASZLZ

15 APR 1961

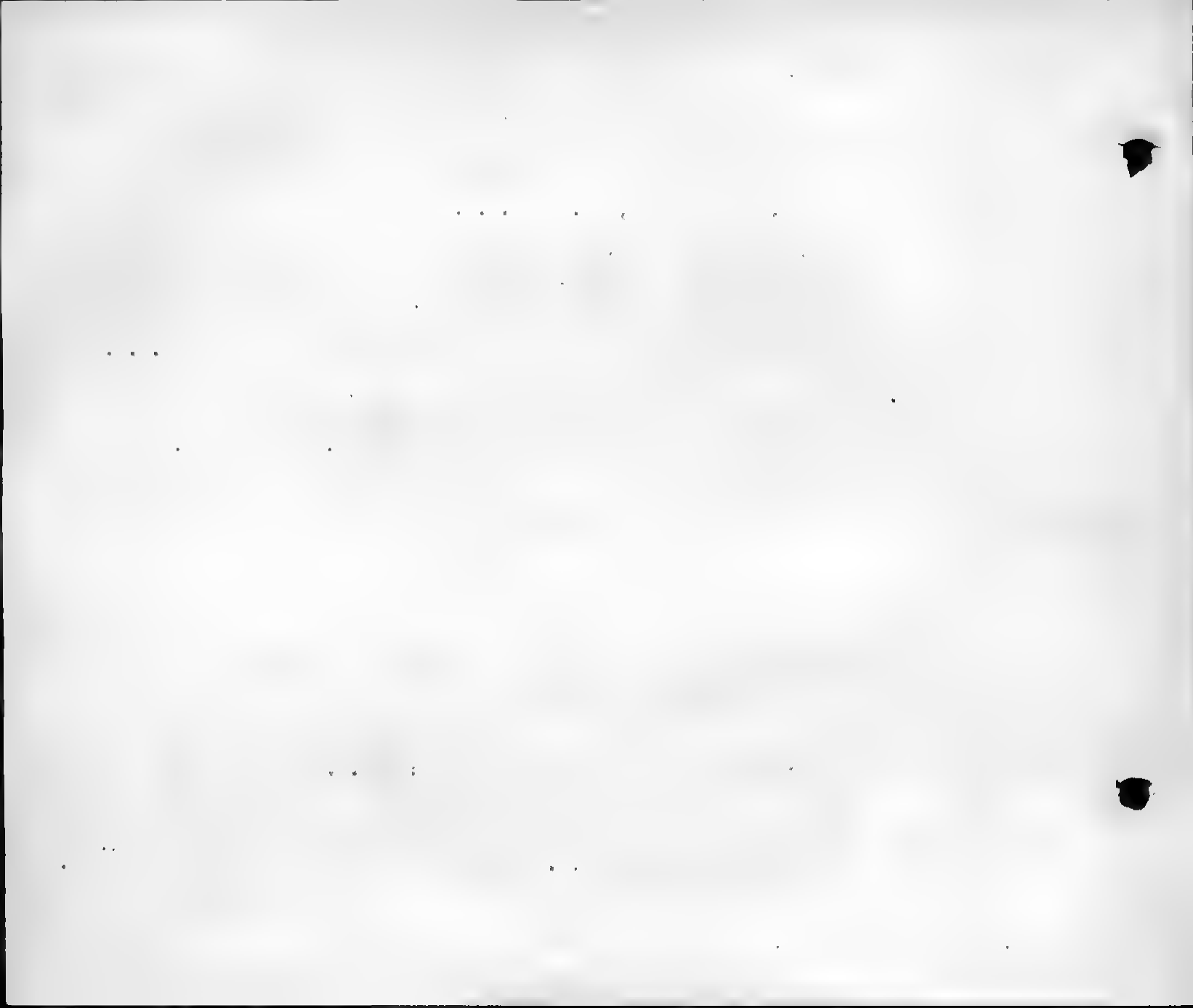
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14999
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 152 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston d. STREET ADDRESS R.F.D. # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Richard Last Kraus		4. DATE OF DEATH Month April Day 3 Year 19 61					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1956	9. AGE (In years lost birthday) yrs 5	IF UNDER 1 YEAR Months 5 Days 11 Hours 11 Min. 5		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Kendall H. Kraus			14. MOTHER'S MAIDEN NAME Rita Stenker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO 204 Acute Lymphatic Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphatic Leukemia DUE TO (c) Acute Lymphatic Leukemia INTERVAL BETWEEN ONSET AND DEATH 24 hours 9 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1960			
20f. (City or town) 1961		20g. (County) 1961		20h. (State) 1961			
21. I certify that (I) (this hospital) attended the deceased from November 2, 1960 to April 3, 1961 , that (I) (we) last saw the deceased alive on April 3, 1961 , and that death occurred at 4:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Richard E. Rieselbach M.D.		22b. DATE 4/3/61		22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF April 6, 1961		23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery			
23d. LOCATION (City, town, or county) Preston, Maryland		23e. (State) Md.					
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR APR 10 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

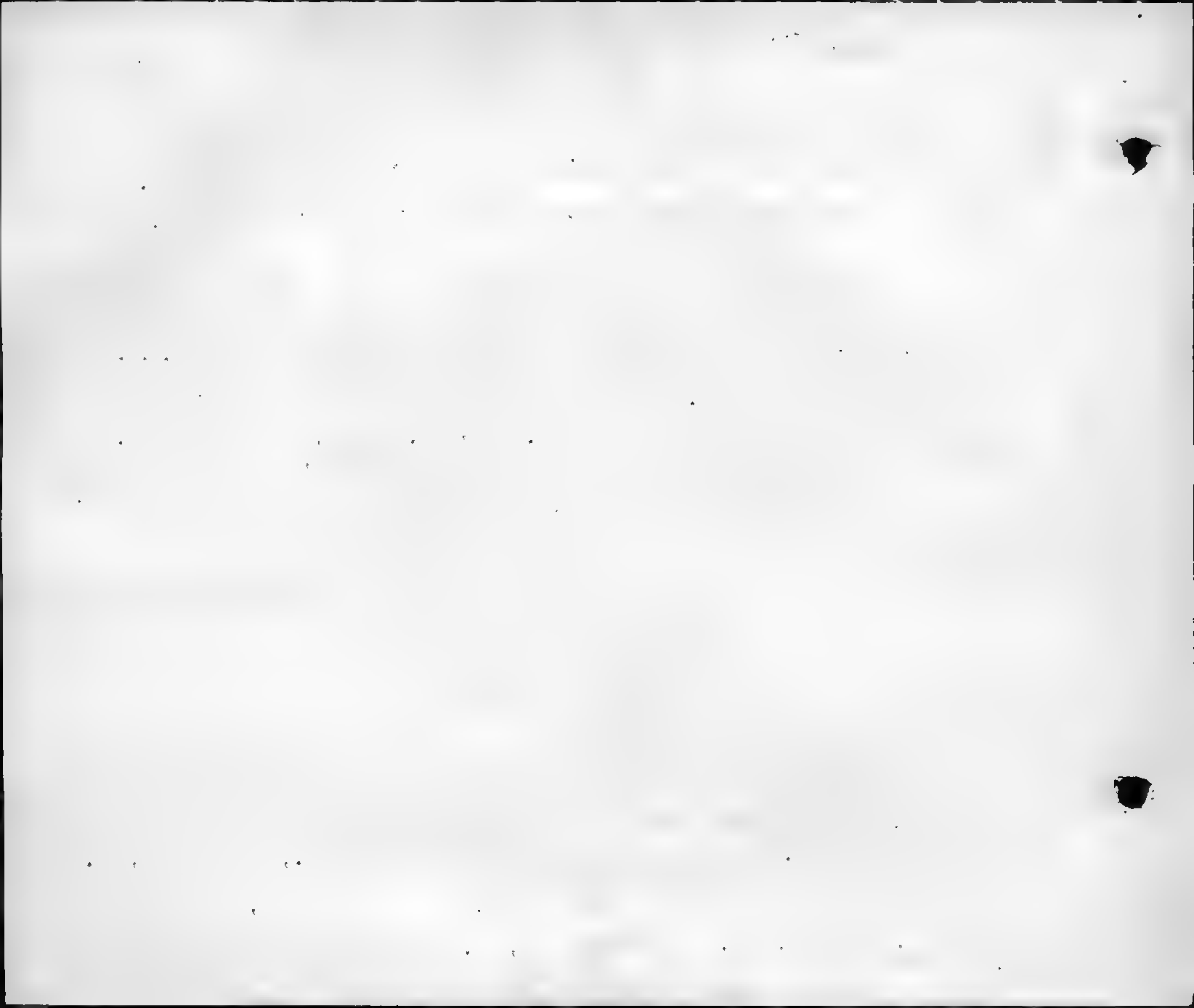
VR A15 (4)
15M 9/59

4500
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

04491

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>MONTGOMERY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>	
c. LENGTH OF STAY IN lb. <i>3 1/2 yrs.</i>		d. STREET ADDRESS <i>16th & Colesville Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Belle</i> Last <i>Lentz</i>		4. DATE OF DEATH Month <i>April</i> Day <i>26</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>14 Mar. 1882</i>
9. AGE (In years last birthday) <i>79</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>W. VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Matthew Hennen</i> E. HENNEN		14. MOTHER'S MAIDEN NAME <i>Mary Louise Pickenpugh</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Mrs. Louise L. Hexter</i>		Address <i>3810 Everett St. Kensington, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Influenza</i> DUE TO <i>181X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ASCD</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <i>Nov. 1957</i> to <i>April 25, 1961</i> , that (i) (we) last saw the deceased alive on <i>April 25, 1961</i> , and that death occurred on <i>4:30 AM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Horace W. Bernton</i> M.D.		22b. DATE SIGNED <i>4/26/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>HORACE W. BERTON</i>		22d. ADDRESS <i>4743 Bradley Blvd., Chevy Chase, Md.</i>	
23a. BURIAL CREMATION REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4/28/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>EAST OAK GROVE CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>MORGANTOWN, WEST VIRGINIA</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond W. Ziska</i> ADDRESS <i>SILVER SPRING, MD.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 1 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles L. Frank</i>			





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

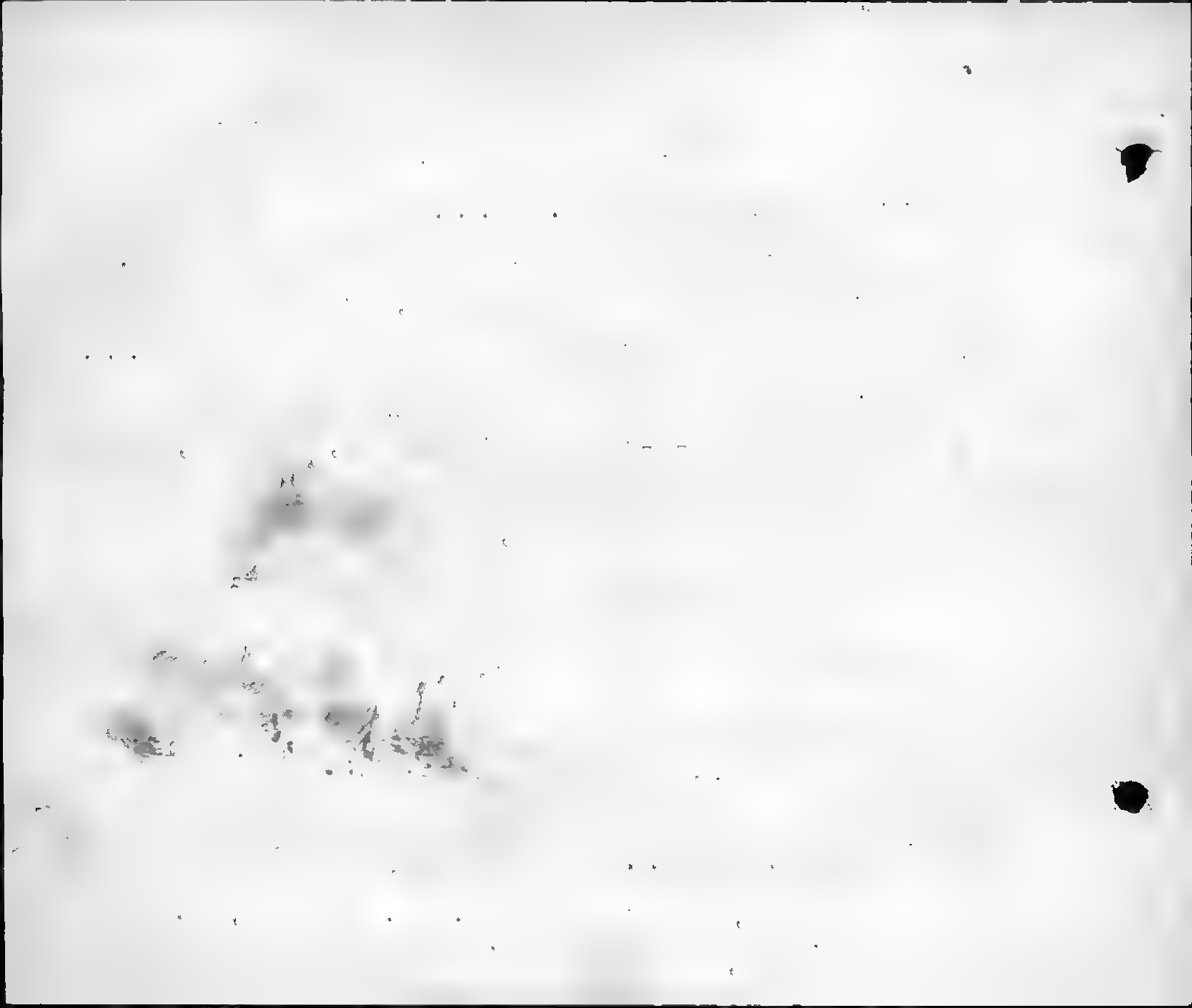
4501

04492

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admittance) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 103 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martin Middle (None) Last Leatherman				4. DATE OF DEATH Month April Day 13 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 13, 1902	
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months 5 Days 7 Hours 0 Min 0		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist				10b. KIND OF BUSINESS OR INDUSTRY Chemical			
13. FATHER'S NAME Martin Leatherman				14. MOTHER'S MAIDEN NAME Barbara East			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO 160-24-2593		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Gastrointestinal hemorrhage							
570X DUE TO (b) Acute yellow atrophy, liver							
DUE TO (c) with questionable acute myelogenous leukemia ? years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 m 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from December 31, 1960 to April 13, 1961 , that (I) (we) last saw the deceased alive on April 13, 1961 , and that death occurred at 5:12 a.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Jerome B. Block</i>				22b. DATE 4/13/61			
22c. PHYSICIAN'S NAME (Type) JEROME B. BLOCK, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 17, 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph W. Foster</i>				25a. REC'D BY REGISTRAR APR 17 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

V. BROADWAY & WILLIAMS
BEL AIR, MD.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film 0292 8/1/61 ink

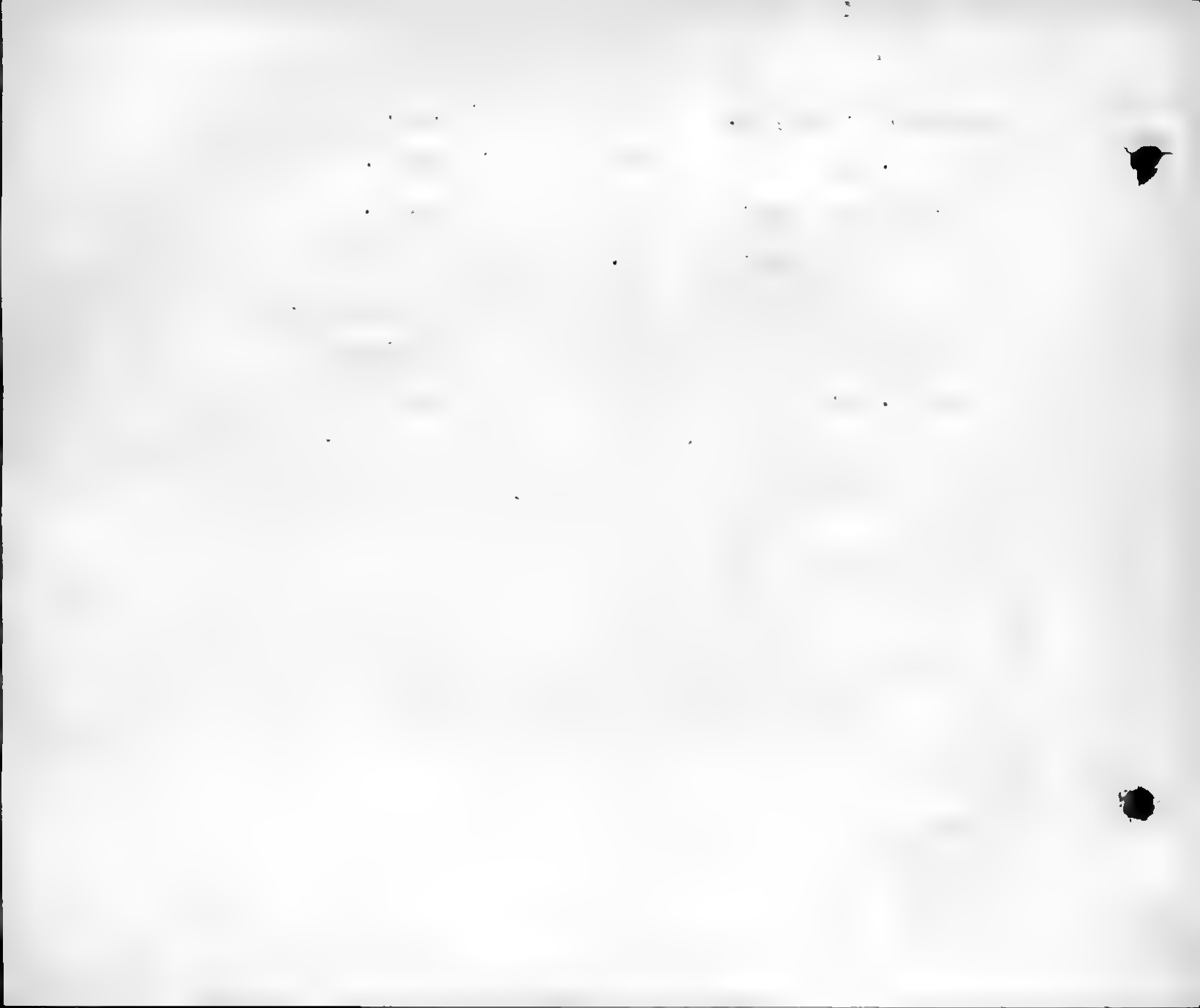
CERTIFICATE OF DEATH

Reg. Dist. No. 014493

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Bellmont - Ashton, Md.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton Md.</u> c. LENGTH OF STAY IN 1b <u>10 Yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bellmont Nursing Home</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> <u>Ashton, Md.</u> b. COUNTY <u>Ashton, Md.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton, Md.</u> d. STREET ADDRESS <u>Ashton, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First <u>Grace</u> Middle <u>Le Merle</u> Last 4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1961</u>		5 SEX <u>F</u> 6 COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B DATE OF BIRTH <u>Aug 1, 1874</u> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Costa Rica</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry D. Norris</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16 SOCIAL SECURITY NO. <u>none</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/18/1961</u> to <u>4/16/1961</u> , that I last saw the deceased alive on <u>4/15/1961</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 Georgia Ave, S/D, Md</u> DATE SIGNED <u>4/17/61</u> ACTUAL SIGNATURE <u>Donald Nelson</u> M.D. PHYSICIAN'S NAME (Type) <u>DONALD NELSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>April 17-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 1961</u>	
ADDRESS <u>Saylorsville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

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MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04494

4503

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON d. STREET ADDRESS 2016 GLEN HAVEN PL. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ENZO LEVY				4. DATE OF DEATH Month Day Year APRIL 21 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1892	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? LATVIA	
13. FATHER'S NAME BENJAMIN ROSS				14. MOTHER'S MAIDEN NAME ANNA ESTHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---		INFORMANT Address SIDNEY LEVY 2404 LILLIAN AVE. SE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction (b) Coronary Thrombosis (c) Arteriosclerosis, generalized PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive vascular disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work Not while at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/20, 1961 to 4/21, 1961 , that I last saw the deceased alive on 4/21, 1961 and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 George Ave, Silver Spring, Md DATE SIGNED 4/21/61 SIGNATURE Donald Nelson M.D. PHYSICIAN'S NAME (Type) DONALD NELSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 23, 1961		22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		22d. LOCATION (City, town, or county) (State) W. HYATTSVILLE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY ADDRESS 5501 14th St NW				24a. REC'D BY REGISTRAR DATE APR 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

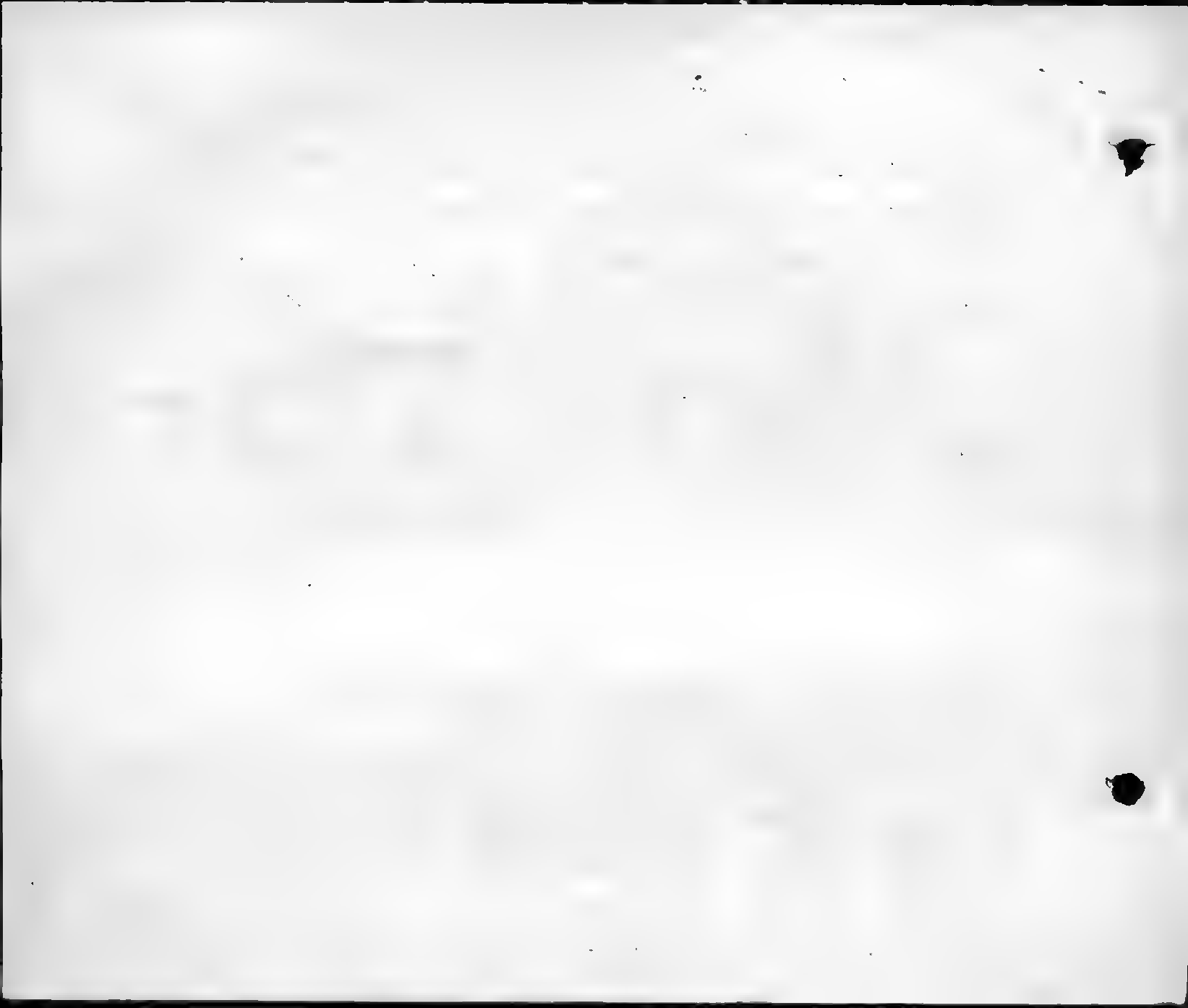
4504
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04495

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>4 years</u>				d. STREET ADDRESS <u>4318 Curtis Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Elizabeth</u> Last <u>Lloyd</u>				4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 2, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>19</u> Min.		11. IF UNDER 24 HRS. Months <u>4</u> Days <u>7</u> Hours <u>19</u> Min.		12. IF UNDER 24 HRS. Months <u>4</u> Days <u>7</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXX XXXXX</u>			
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Wesley Adams</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO <u>None</u>			
17. INFORMANT <u>Mr. John D. Lloyd</u>				Address <u>Law</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> DUE TO <u>551X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebrovascular accident</u> DUE TO <u>arteriosclerosis, generalized</u> (c) <u>10 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>4 weeks</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1957</u> to <u>April 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 7, 1961</u> , and that death occurred at <u>3:20 PM</u> from the causes and on the date stated above				22a. SIGNATURE <u>Robert N. Coale</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>				22b. DATE SIGNED <u>April 7, 1961</u>			
22d. ADDRESS <u>4630 Montgomery Ave Bethesda, Md</u>				22e. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>APR 12 '61</u>			
ADDRESS <u>Bethesda, Maryland</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

(M)

(I)

4505
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04496

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Mont. Co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>5721 Grosvenor Lane</i>			
3. NAME OF DECEASED (Type or print) First <i>JAMES</i> Middle <i>LOWE</i> Last <i>LOWE</i>				4. DATE OF DEATH Month <i>4</i> Day <i>26</i> Year <i>1961</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1880</i>	
9. AGE (In years last birthday) <i>81</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i>		11. BIRTHPLACE (State or foreign country) <i>Ill. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Madison Lowe</i>				14. MOTHER'S MAIDEN NAME <i>Taylor</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no.</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>no.</i>		17. INFORMANT <i>son</i> Address <i>5721 Grosvenor Lane</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Pyelonephritis</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> to <i>April 26, 1961</i> , that (I) (we) last saw the deceased alive on <i>4-26</i> 19 <i>61</i> , and that death occurred on <i>4-26</i> 19 <i>61</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>James W Egan</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <i>7720 W. Wisconsin Ave. Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>4/29/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i>		23d. LOCATION (City, town, or county) (State) <i>WASH. D. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Nanton</i>				25a. REC'D BY REGISTRAR DATE <i>MAY 5 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4506

04497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>32 da</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Audrey</u> Middle <u>Lee</u> Last <u>Howery</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1946</u>	
9. AGE (In years last birthday) <u>15</u> yrs		10. UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min		11. UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Leon Howery</u>				14. MOTHER'S MAIDEN NAME <u>Crimes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Leon Howery, as above.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>401.1</u> DUE TO <u>Multiple Trauma by Motor Vehicle</u> Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>Road State HFA</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/15/1961</u> to <u>4/18/1961</u> , that (I) (we) last saw the deceased alive on <u>4/18/1961</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Allen J. O'Neill</u> M.D.				22b. DATE SIGNED <u>4/18/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill MD</u>				22d. ADDRESS <u>8601 Old Georgetown Rd, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Darnestown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1331 E. Montg. Ave. Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 24 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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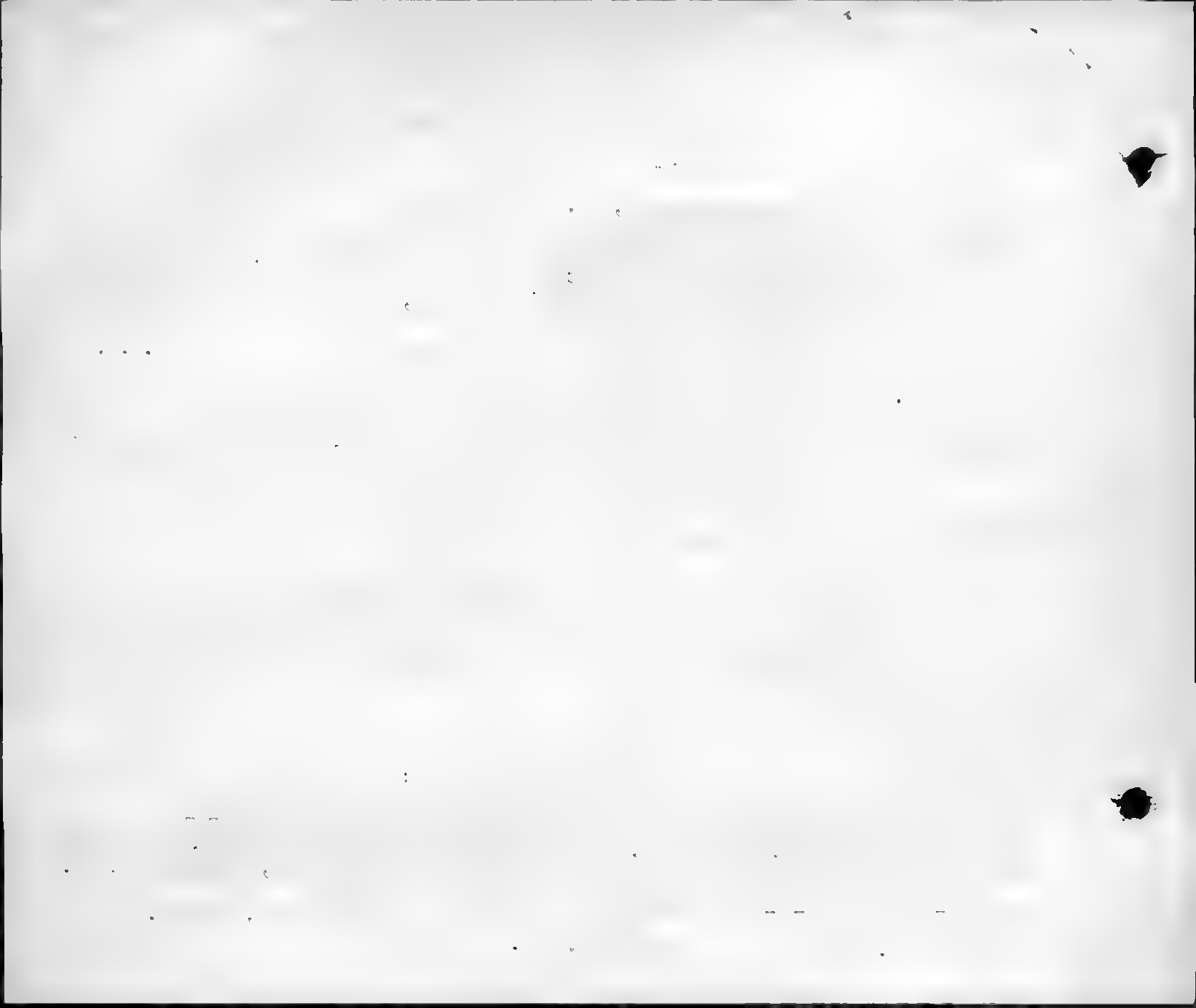
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04498

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Connecticut b. COUNTY Trumbull			
c. LENGTH OF STAY IN 1b 115 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trumbull			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 27 Bear Den			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				45x-			
3. NAME OF DECEASED (Type or print) First Middle Last Paul Joseph Lucas				4. DATE OF DEATH Month Day Year April 8 19 61			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH September 3, 1959	9 AGE (In years last birthday) 1 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Lucas				14. MOTHER'S MAIDEN NAME Rose Marie Garrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO 2-4-3 Conditions, if any which gave rise to immediate cause (c) stating the underlying cause lost (b) Renal Failure DUE TO (c) Acute Lymphatic Leukemia						INTERVAL BETWEEN ONSET AND DEATH 12 Hours 4 Weeks 8 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from December 14, 19 60 to April 8, 19 61 , that (I) (we) last saw the deceased alive on April 8, 19 61 , and that death occurred at 9:25 AM from the causes and on the date stated above.							
22a. SIGNATURE Edward E. Morse		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4-8-61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward E. Morse M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-9-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Lawncroft Cemetery		23d. LOCATION (City, town, or county) (State) Fairfield, Conn.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE APR 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Fuchs	



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4508

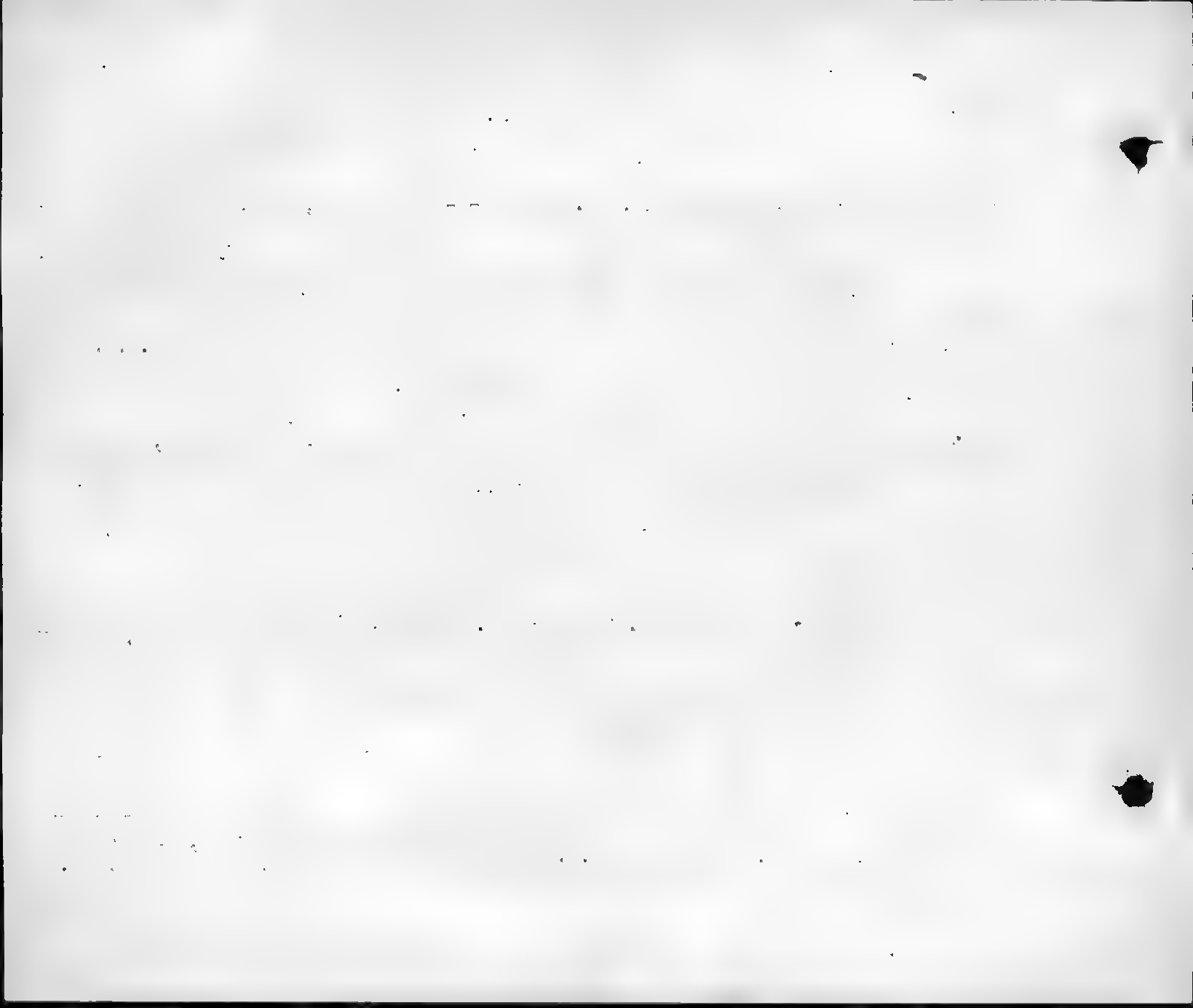
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission a. STATE Alabama b. COUNTY Birmingham c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 408-3 d. STREET ADDRESS 817 A - 22nd Place, South e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlie Middle (None) Last Lucious				4. DATE OF DEATH Month April Day 11 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 August 1909	
9. AGE (in years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alf Lucious				14. MOTHER'S MAIDEN NAME Lena Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cryptococcal Meningitis 134.1 DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cryptococcal Bacteremia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 1/Acute Myocardial Infarction. 2/Silicosis. 3/Chronic Obstructive Emphysema.						INTERVAL BETWEEN ONSET AND DEATH Months Weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from March 23 , 19 61 , to April 11 , 19 61 , that he (we) last saw the deceased alive on April 11 , 19 61 , and that death occurred at 7:40 PM on the causes and on the date stated above.							
22a. SIGNATURE Robert R. Carpenter				22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
22c. PHYSICIAN'S NAME (Type) ROBERT R. CARPENTER, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Ship		23b. DATE THEREOF 4-13-61		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Birmingham, Alabama	
24. FUNERAL DIRECTOR'S SIGNATURE Progers Funeral Home Inc. 389-R.D. Ave. N.W.				25a. REC'D BY REGISTRAR APR 13 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kious	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

4509

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04500

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if instit. on Res. before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Leesburg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route # 4, Leesburg, Va.</u> d. STREET ADDRESS <u>Route # 4, Leesburg, Va.</u>	
3. NAME OF DECEASED (Type or print) <u>Rossmore Denman LYON</u>		4. DATE OF DEATH Last <u>April</u> Month <u>8</u> Day <u>19</u> Year <u>61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. FATHER'S NAME <u>George Morgan LYON</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI-WWII</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth FAUST</u>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction Myocardium, Post Operative</u> 420. } DUE TO Conditions, if any, which } (b) gave rise to immediate cause } (a), stating the underlying } DUE TO cause last. } (c)		16. SOCIAL SECURITY NO <u>Hospital Records</u>	
17. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 8, 1961</u> to <u>April 8, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 8, 1961</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>J. W. Brown</u>		22b. DATE SIGNED <u>4-8-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. W. BROWN Lcdr MC USN</u>		22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Arlington</u>		23b. DATE THEREOF <u>4-11-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u>		24. ADDRESS <u>R. A. Pumphrey Funeral Home, Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>APR 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04501

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town Takoma Park
c. LENGTH OF STAY IN 1b 5 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash SAN & Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town Silver Spring
d. STREET ADDRESS 9619 Clearview Pl

3. NAME OF DECEASED (Type or print) DANIEL BERNARD LYONS, JR.
4. DATE OF DEATH 4-16-1961
Month Day Year

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 7-13-06
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Mln.

10. INSPECTION (Give kind of work done during most of working life, even if retired) D.C. Sanitary Eng. Comm. 10b. KIND OF BUSINESS OR INDUSTRY Wash. D.C. 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME DANIEL B. LYONS 14. MOTHER'S M maiden name SABINA COONEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO 16. SOCIAL SECURITY NO. 578-24-8671 17. INFORMANT Mrs. Louise E. Lyons, 9619 Clearview Place Silver Spring, Md. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis
(a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October 1955 to April 15, 1961 that (I) (we) last saw the deceased alive on April 15, 1961, and that death occurred at 2:25 PM, from the causes and on the date stated above.

22a. SIGNATURE Bennett A. Robin 22b. DATE SIGNED 4/17/61
22c. PHYSICIAN'S NAME (Type) BENNETT A. ROBIN 22d. ADDRESS 317 UNIV. BLVD. EAST SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4/19/61 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY 23d. LOCATION (City, town or county) (State) PRINCE GEORGE COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Dumbelly, Inc. ADDRESS SILVER SPRING, MD. 25a. REC'D BY REGISTRAR DATE APR 19 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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(M)

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04502

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Penn.
b. COUNTY Northumberland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9th. Street
d. STREET ADDRESS 9th. Street

3. NAME OF DECEASED (Type or print)
First Louis Middle Mancini Last Mancini

4. DATE OF DEATH
Month April Day 26 Year 19 61

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 6/13/33

9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. 27 yrs. 27 yrs. 27 yrs. 27 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant
10b. KIND OF BUSINESS OR INDUSTRY Restaurant owner
11. BIRTHPLACE (County & State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Vincent Mancini
14. MOTHER'S MAIDEN NAME Earnstine Celletti

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Mother Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HODGKINS DISEASE
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE
INTERVAL BETWEEN ONSET AND DEATH 15 MOS.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

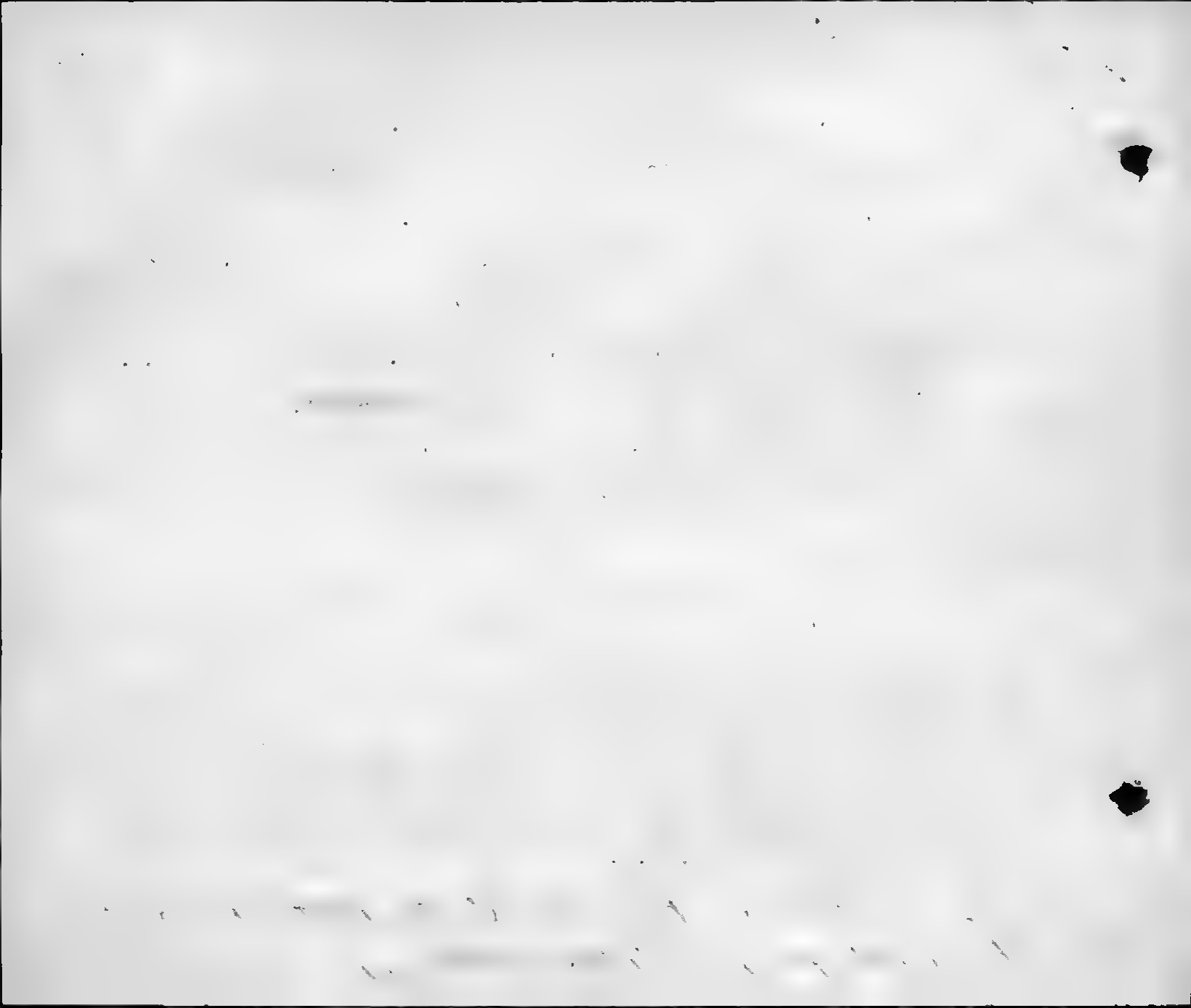
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/8, 1960, to 4/26, 1961, that (I) (we) last saw the deceased alive on 4/26/61, and that death occurred at 2:30 AM, from the causes and on the date stated above.

22a. SIGNATURE John H. Tuohy
22c. PHYSICIAN'S NAME (Type) John H. Tuohy, M.D.
22d. ADDRESS 7720 WISCONSIN AVE BETHESDA 14, MD.

23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 4/29/61
23c. NAME OF CEMETERY OR CREMATORY River View Cemetery
23d. LOCATION (City, town or county) (State) Northumberland Pa.

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Sampson ADDRESS 7557 Wisc Ave Bethesda, Md.
25a. REC'D BY REGISTRAR APR 28 '61
25b. REGISTRAR'S SIGNATURE Clarence S. Thomas



CERTIFICATE OF DEATH

Reg. Dist. No. 04503

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 9 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitorium		e. STREET ADDRESS 5605 Wilson Lane	
3. NAME OF DECEASED (Type or print) Anna First MP. Middle Martin Last		4. DATE OF DEATH April 20 1961 Month April Day 20 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-1863
9. AGE (In years last birthday) 98 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVERNMENT		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) TENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED MARTIN		14. MOTHER'S MAIDEN NAME SARAH CAROLINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO ---	
17. INFORMANT MR. O. G. WHITLOW Address BETHESDA, MD 5605 Wilson Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/80 1961 to present 19 --- , that I last saw the deceased alive on 4/20 1961 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8805 Conn Ave DATE SIGNED 4/20/61			
ACTUAL SIGNATURE John B. Umhan M.D.		PHYSICIAN'S NAME (Type) John B. Umhan Cherry Chase 15, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-24-1961	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) WASHINGTON, DC
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. ... ADDRESS 1756 P.A. ...		24a. REC'D BY REGISTRAR APR 24 '61	24b. REGISTRAR'S SIGNATURE Charles J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4513

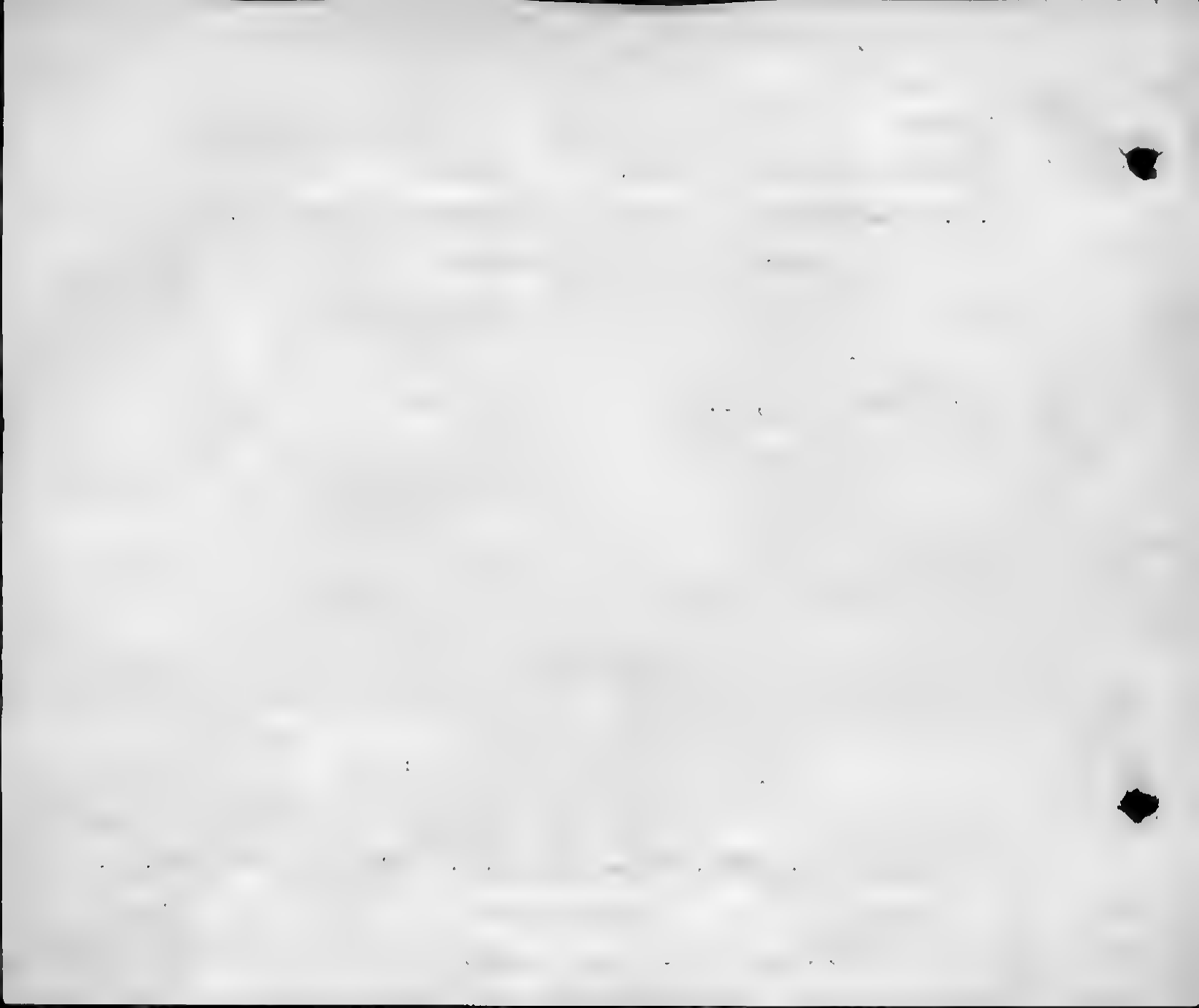
04504

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u> d. STREET ADDRESS <u>799 West Ocean View Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>George Eugene MARTIN, JR.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1-21-61</u>		9. AGE (In years) <u>4</u> UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> last birthday) <u>4</u> Months <u>4</u> Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Eugene MARTIN, SR.</u>		14. MOTHER'S MAIDEN NAME <u>Janet Sue DECKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Hospital, Records</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>154.5</u> IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 5, 1961</u> to <u>April 20, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 20, 1961</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Fred W. Grelio</u> 22b. DATE SIGNED <u>4-21-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Fred W. GRELIO, LT, MC, USN</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment</u> 23b. DATE THEREOF <u>4-22-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u> 23d. LOCATION (City, town or county) <u>Peoria</u> <u>Illinois</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co., 1400 Chapin St., NW, WashDC</u>		25a. REC'D BY REGISTRAR <u>DATE APR 24 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

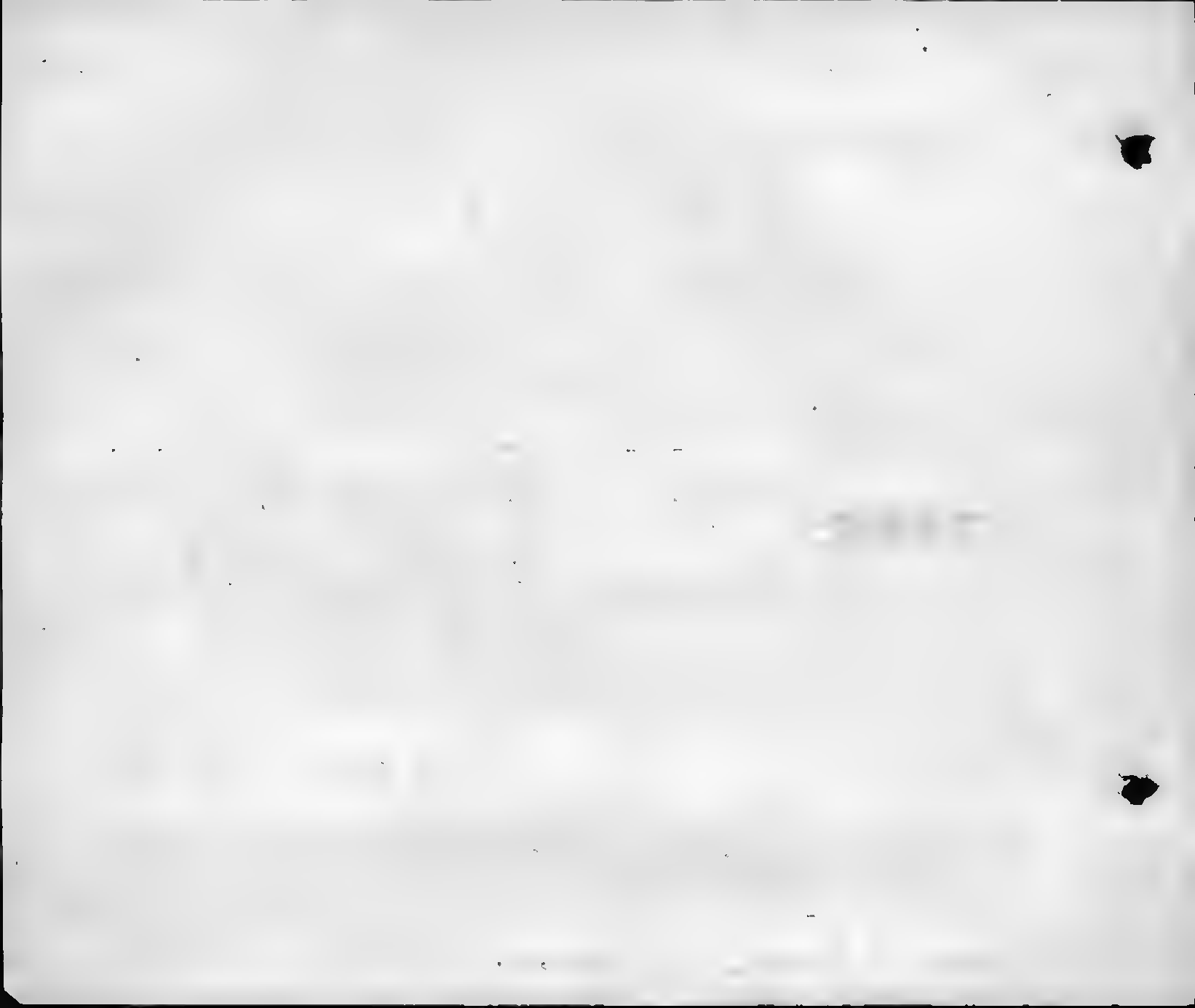
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04505

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>5 1/2</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rochville</u> d. STREET ADDRESS <u>Route #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carl Casper May</u>		4. DATE OF DEATH Month Day Year <u>April 23 1961</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>11-2-1917</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd jobs</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Casper A. May</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-018-157</u>	
17. INFORMANT Address <u>Wilbert May (brother) Gaithersburg, Md. Route 1</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive encephalopathy</u> 334X DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Possible renal artery or aortic partial obstruction?</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>4/18, 1961</u> to <u>4/22, 1961</u> , that (2) (we) last saw the deceased alive on <u>4/22, 1961</u> , and that death occurred at <u>4:50 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Allen J. O'Neill M.D.</u>		22b. DATE SIGNED <u>APR 26 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill M.D.</u>		22d. ADDRESS <u>8601 Old Georgetown Rd, Bethesda MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-25-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Montgomery Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis K. Barber</u>		25a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>		25c. ADDRESS <u>Laytonsville, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **14506**

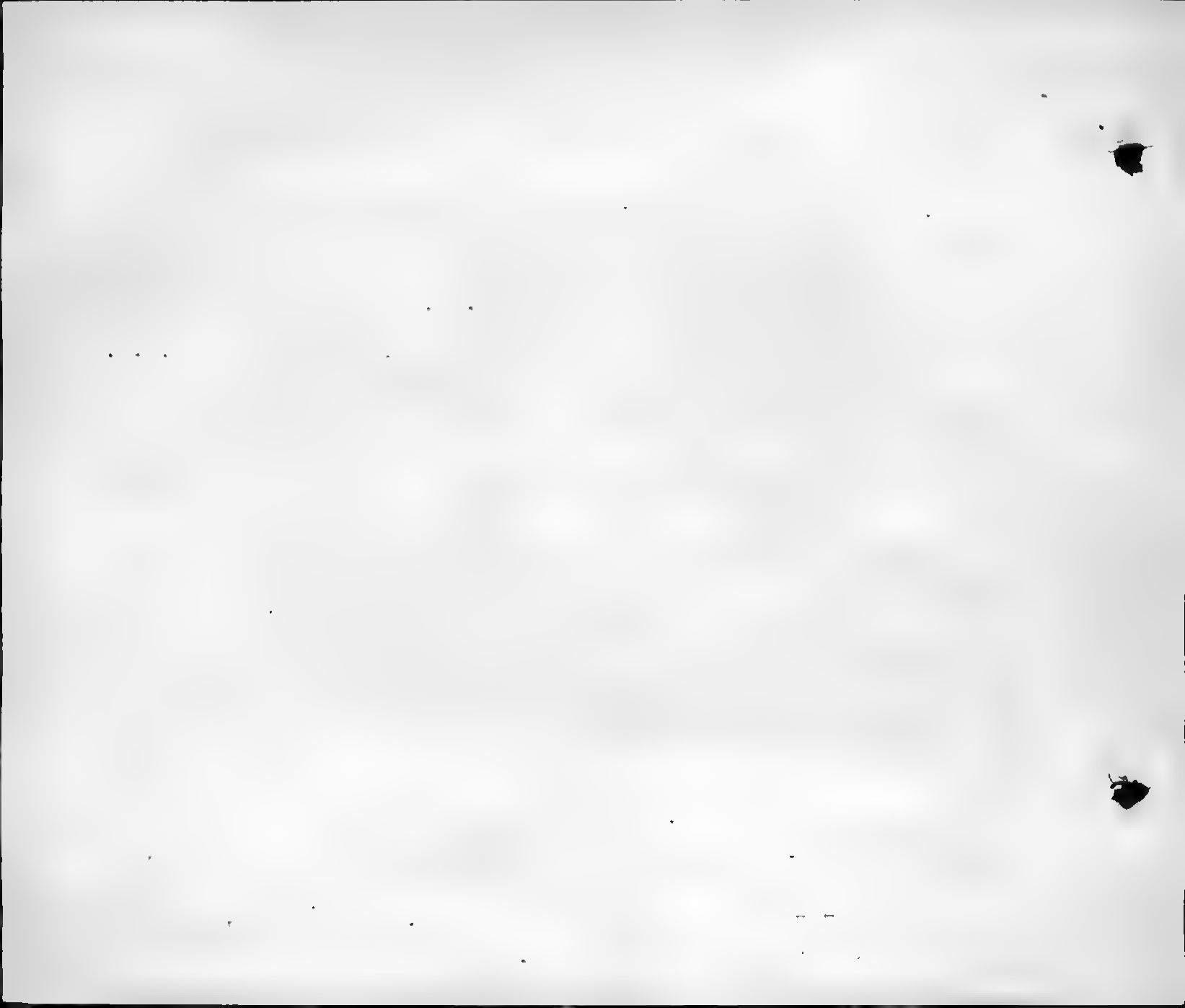
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4809 Middlesex Lane, Bethesda				d. STREET ADDRESS 4809 Middlesex Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ronald Walter May				4. DATE OF DEATH Month April Day 3 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1922		9. AGE (In years last birthday) 38 yrs	10. IF UNDER 1 YEAR Months 1 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper reporter			10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nicholas Bradford May				14. MOTHER'S MAIDEN NAME Renata Zich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO		17. INFORMANT Jeanne Smith May, 4809 Middlesex Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET OF DEATH AND DEATH sudden						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED April 3, 1961							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-61		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PEMPHREY Bethesda, Md.				24a. REC'D BY REGISTRAR DATE APR 6 '61		24b. REGISTRAR'S SIGNATURE <i>Carleton S. Hume</i>	



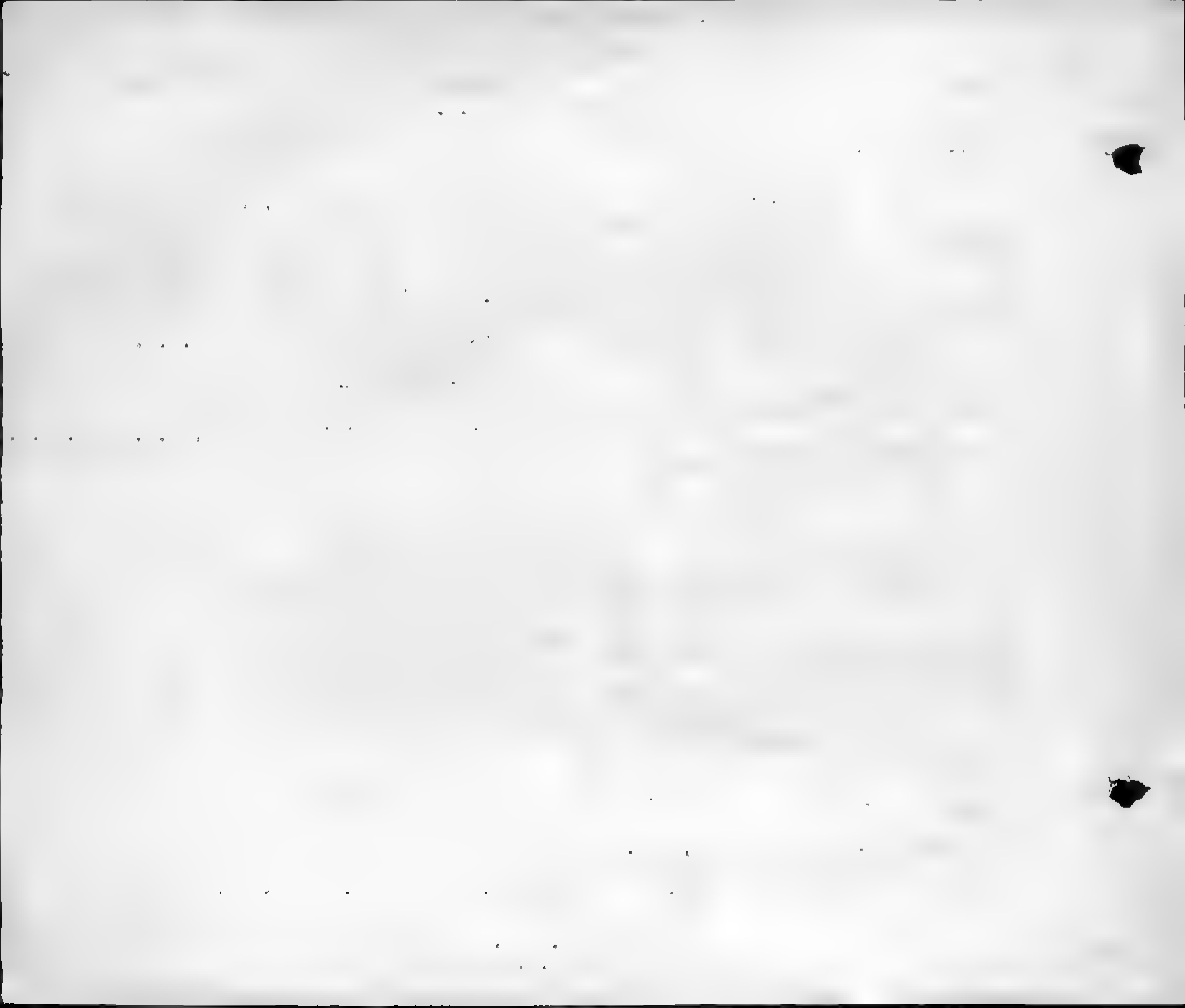
CERTIFICATE OF DEATH

Reg. Dist. No.

04507

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hava Rest Nursing Home		d. STREET ADDRESS 1618 22nd Street S.E.	
3. NAME OF DECEASED (Type or print) First Ella Middle Rose Last Mayhugh		4. DATE OF DEATH Month April Day 9th Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31st 1872
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR: Months 72 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Burke		14. MOTHER'S MAIDEN NAME Elizabeth Brady	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs Nellie Cogan		Address 1618 22nd St. S.E. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Coronary artery - atherosclerosis DUE TO Electrocardiogram Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 72 Months (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct-7 , 19 60 to April 9 , 19 61 , that I lost saw the deceased alive on April 9 , 19 61 , and that death occurred at 35-244 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. Chester Brady, M.D. 35-244 APR 11 '61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/12/61	
22c. NAME OF CEMETERY OR CREMATORY Gainesville Methodist		22d. LOCATION (City, town or county) (State) Gainesville Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M.W. Chambers Co.		24. REC'D BY REGISTRAR APR 11 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

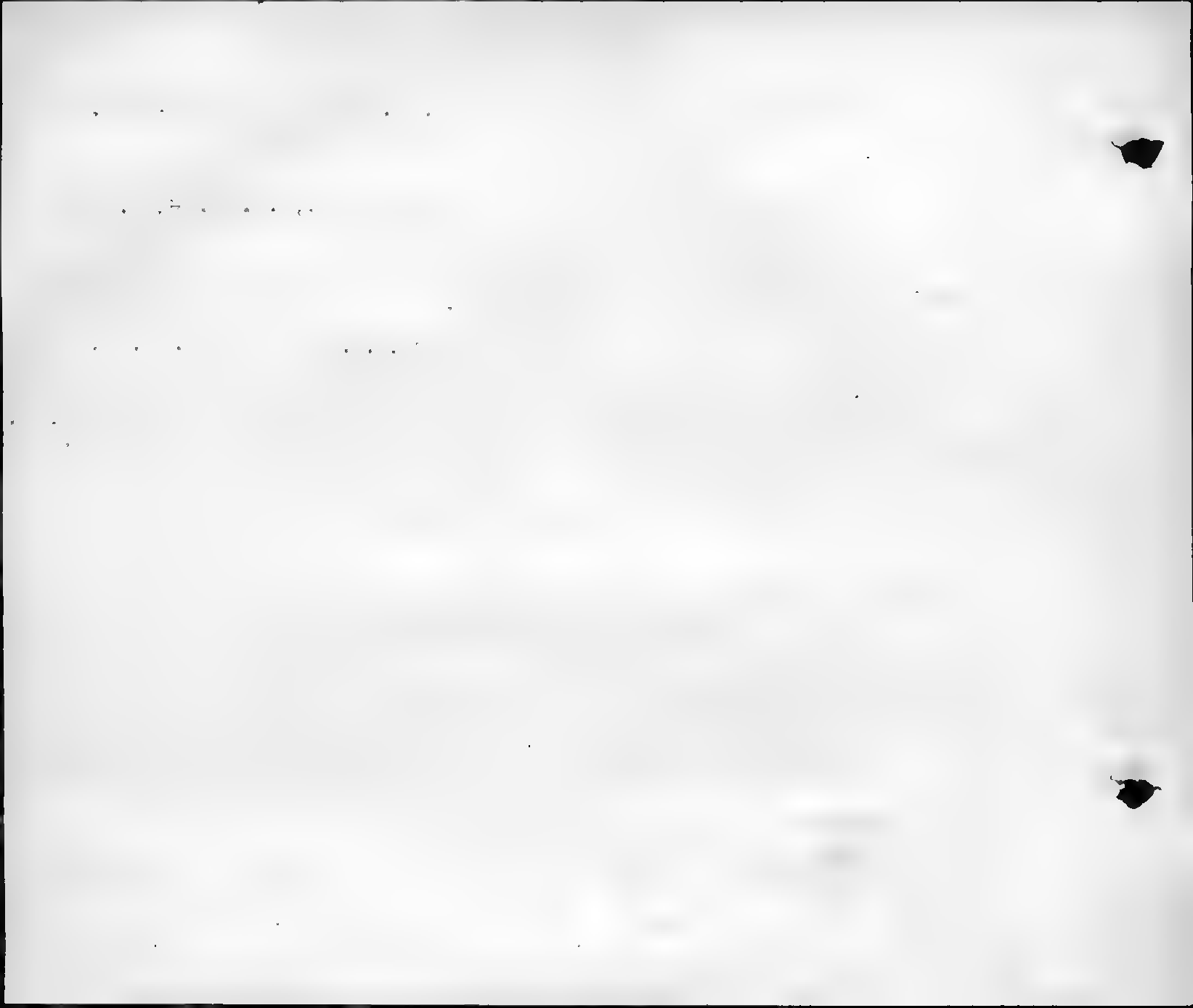
VR A15 (4)
ISM 9/59

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4517

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04508

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN TB unobtainable	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		e. STREET ADDRESS 4615 44th Street, N. W., Wash., D. C.	
3. NAME OF DECEASED (Type or print) First Lillie Middle McAlexander Last McAlexander		4. DATE OF DEATH Month April Day 30 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1882
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginian S.S.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Spencer		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sanitarium records		Address Kensington, Md. 3000 McComas Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and Pyelonephritis 4-22-61 DUE TO Gave rise to immediate cause (b), stating the underlying cause (c) DUE TO Congestive heart failure Arteriosclerotic cardiovascular disease unknown PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Kyphoscoliotic Pulmonary Disease, 20 years.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-6-59 to 4-29-61 , that (I) met lost saw the deceased alive on 4-29-61 , and that death occurred at 8:34 AM, from the causes and on the date stated above			
22a. SIGNATURE Edward W. Youngblood		22b. DATE SIGNED 1961	
22c. PHYSICIAN'S NAME (Type) EDWARD W. YOUNGBLOOD		22d. ADDRESS WASHINGTON CLINIC, WASHINGTON, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5/2/61	
23c. NAME OF CEMETERY OR CREMATORY Davis Cemetery		23d. LOCATION (City, town, or county) (State) Shipman, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The H. H. Hens Co.		25a. REC'D BY REGISTRAR MAY 3 '61	
25b. REGISTRAR'S SIGNATURE William S. Kincaid		25c. DATE MAY 3 '61	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

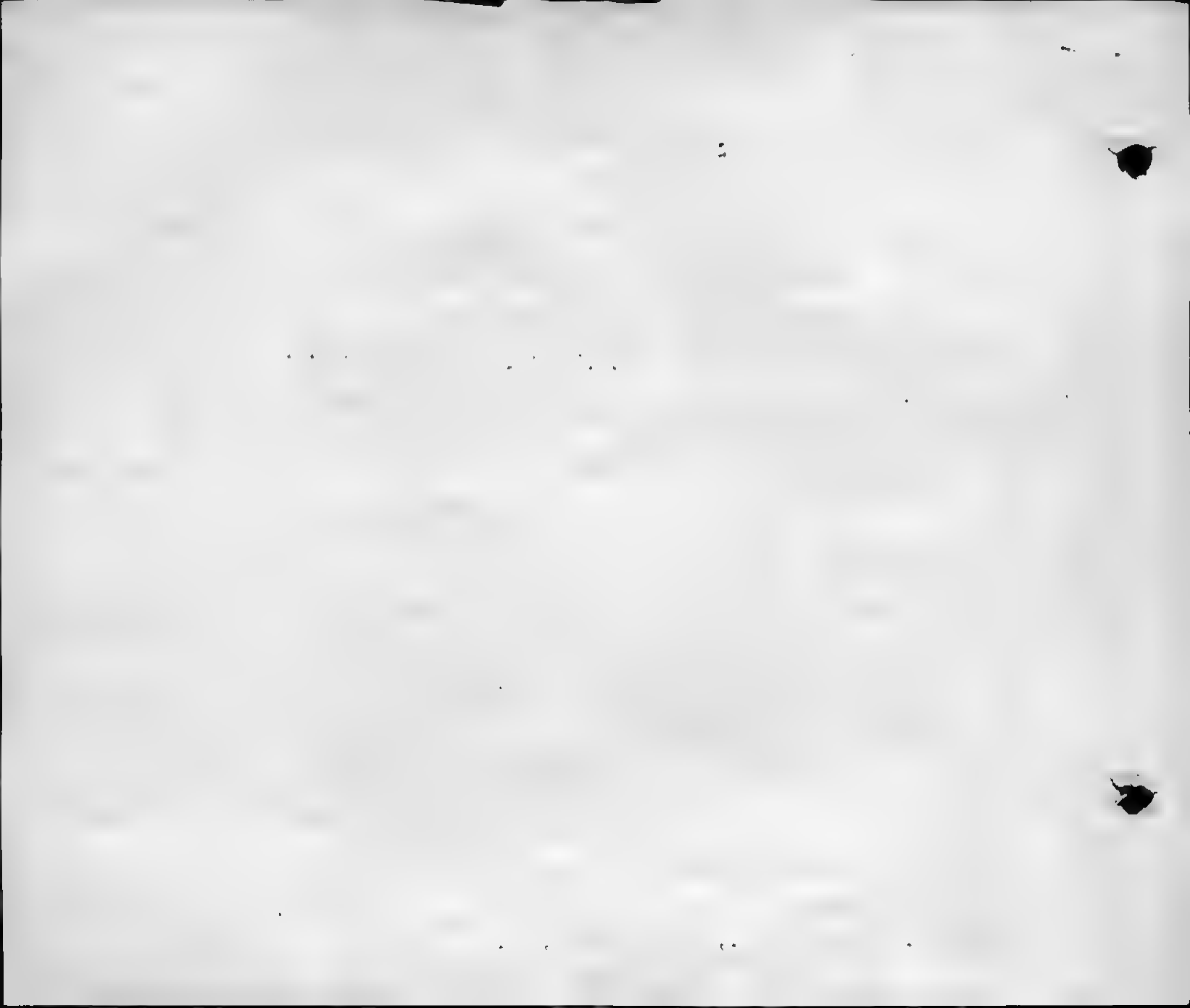
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04509

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>28 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sam + Hosp</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Res dance before admision) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>GAIL 11602 32002 ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Agnes Elizabeth McCaffrey</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-6-1903</u> 9. AGE (In years last birthday) <u>58</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER & Engraving Bureau of Printing U.S. Gov't.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D.C.</u> 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u></p>		<p>4. DATE OF DEATH <u>Apr 8 1961</u> 13. FATHER'S NAME <u>JOHN J. BOYD</u> 14. MOTHER'S MAIDEN NAME <u>IDA unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Hosp Record</u> Address _____</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 116.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1st 2nd 3rd degree burn involving 80% body</u> DUE TO (c) <u>29 hrs</u></p>		<p>19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a, b, c.</p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Clothes caught afire while burning trash at home</u></p>	
<p>20c. TIME OF INJURY Month, Day, Year <u>2-08 p.m. 4-7 1961</u></p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Silver Spring</u> (County) <u>montg</u> (State) <u>md</u></p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <u>Frank J. Broschant</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-9-61</u> Address (Street, city, town, or county) _____</p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>22b. DATE THEREOF <u>4/15/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u> 22d. LOCATION (City, town, or country) <u>PRINCE GEO. COUNTY, MARYLAND</u> (State) _____</p>	
<p>23. FUNERAL DIRECTOR <u>WERNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u></p>		<p>24a. REC'D BY REGISTRAR <u>APR 19 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u></p>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4515

04510

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>15 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>2501 Van Buren Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Maude Lister McCahan</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1961</u>		5. SEX <u>Female</u>									
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7, 1875</u>									
9. AGE (In years last birthday) <u>86</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE County & State, or foreign country <u>BALTIMORE, MD</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Glen Rust</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Lister</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Washington Sanitarium and Hospital</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Asphyxiation + ASD to congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>18 hours</u> DUE TO (b) <u>Asphyxiation</u> DUE TO (c) <u>Asphyxiation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Month, Day, Year <u>4/3</u> 19 <u>61</u> Hour a.m. <u>19</u> p.m. <u>19</u>									
21. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> 19 <u>61</u> to <u>4/4</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>4/3</u> 19 <u>61</u> and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above.		22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/4/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>17105 RIGGS RD. HYATTSVILLE, MD.</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>									
23d. LOCATION (City, town or county) <u>Baltimore County, Md.</u>		23e. REC'D BY REGISTRAR <u>APR 5 '61</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul St., Baltimore 2</u>		24a. ADDRESS <u>1217 St. Paul St., Baltimore 2</u>		24b. DATE <u>APR 5 '61</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04511

wt 3 lbs 3 oz. 5520

1. PLACE OF DEATH
a. COUNTY Montgomery **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 34 hr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg
d. STREET ADDRESS 15 Water St Apt 4A

3. NAME OF DECEASED (Type or print) DAVID RUSSELL McCATHAM
4. DATE OF DEATH April 7 1961
5. SEX Male 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH April 5 1961
9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months 1 Days 10 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE, County & State, or foreign country, MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Rodney Rathbone McCatham 14. MOTHER'S MAIDEN NAME Carole Lee Frye

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Mother - Address 15 Water St Apt 4A Gaithersburg

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)
DUE TO (c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year 4-6-1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

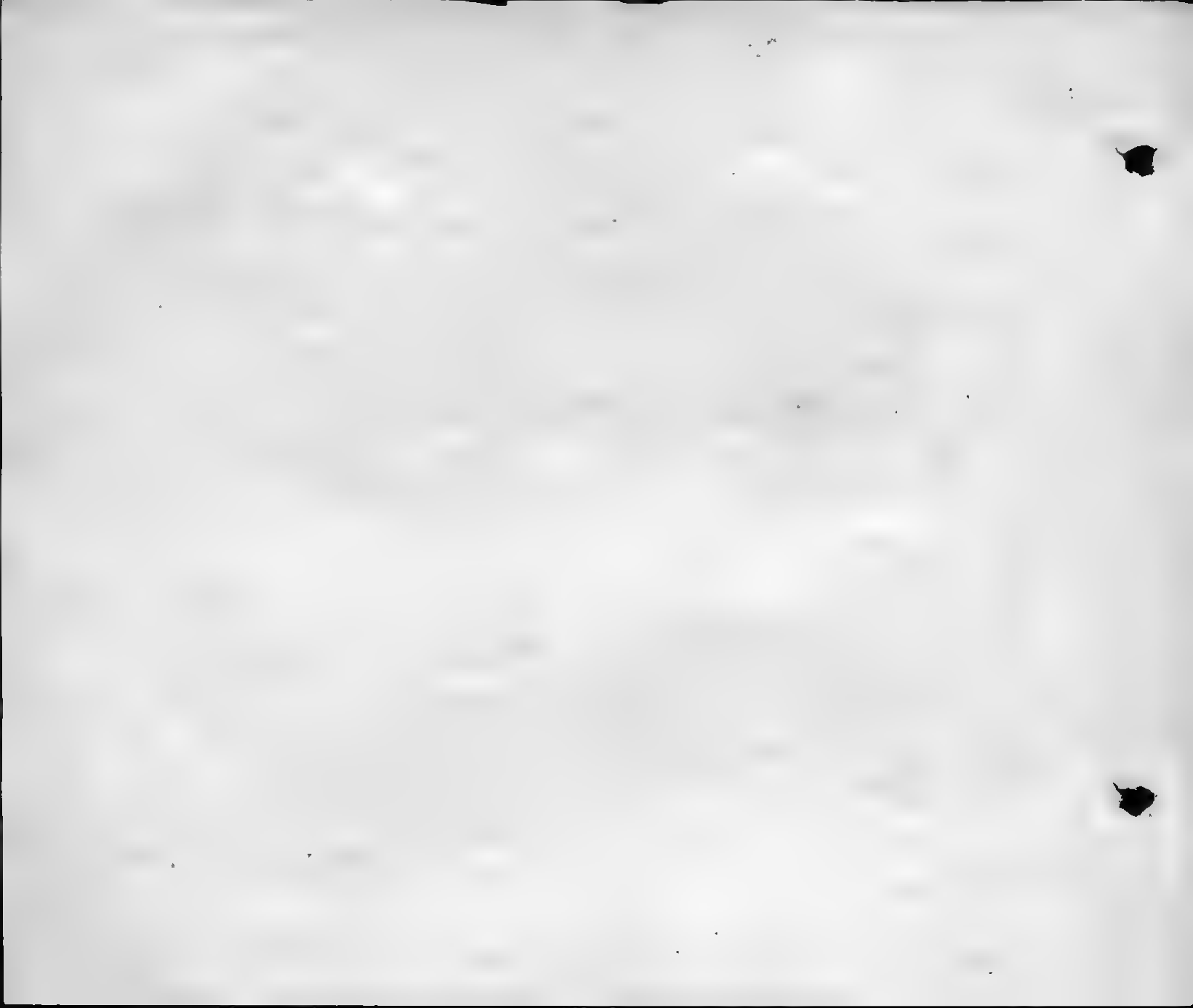
21. I certify that (I) (this hospital) attended the deceased from 4-6-1961 to 4-7-1961, that (I) (we) last saw the deceased alive on 4-7-1961, and that death occurred at 9:55 A.M. from the causes and on the date stated above.

22a. SIGNATURE Roger H. Bergstrom M.D. 22b. DATE SIGNED APR 11 '61
22c. PHYSICIAN'S NAME (Type) Roger H Bergstrom 22d. ADDRESS Rockville Medical Bldg. Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-9-61 23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery 23d. LOCATION (City, town or county) Gaithersburg (State) MD.

24. FUNERAL DIRECTOR'S SIGNATURE John S. Sartin ADDRESS 316 E. Diamond Gaithersburg, Md. 25a. REC'D BY REGISTRAR APR 11 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

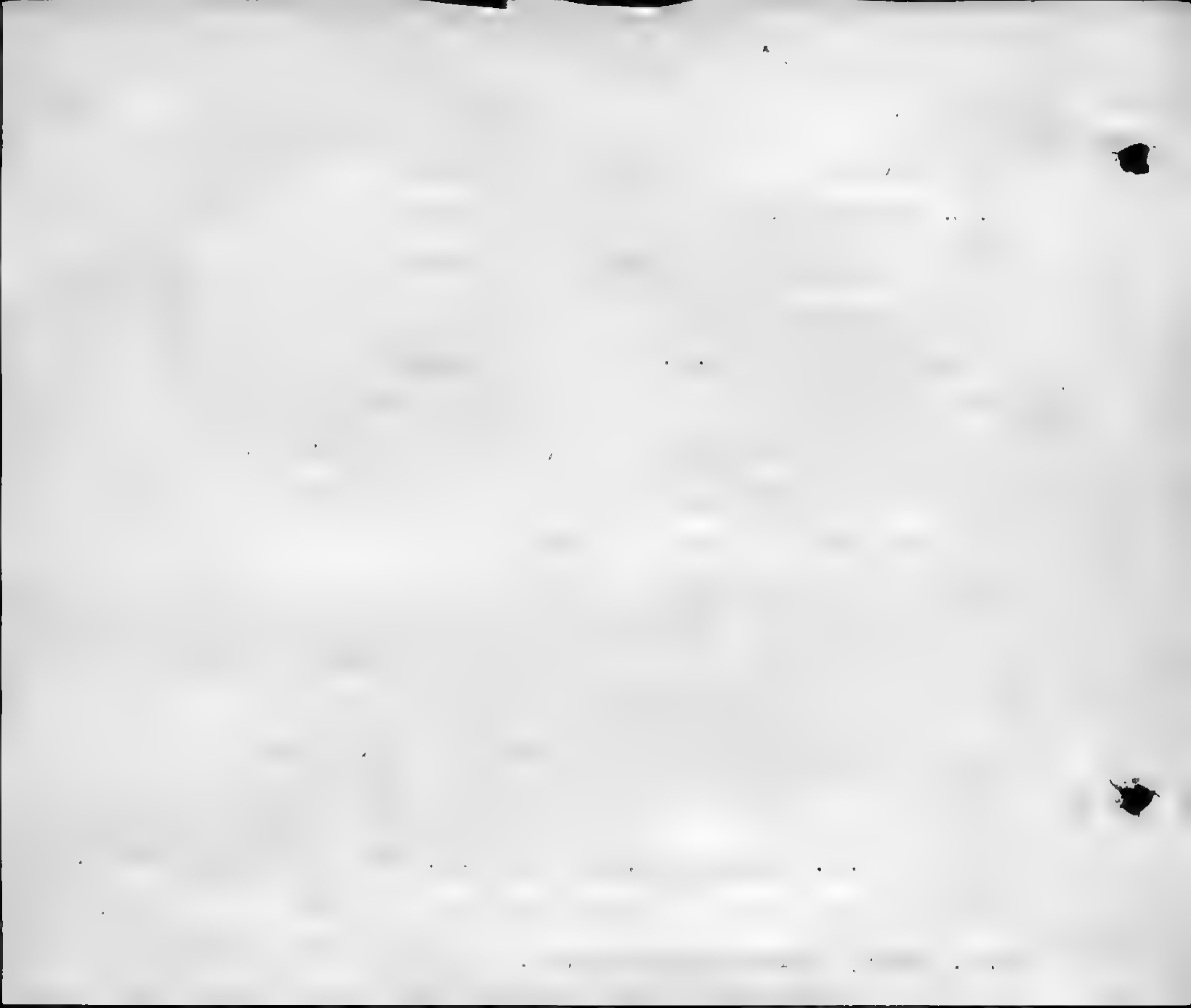
VR A15 (4)
15M 9/60

4521

404512

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 122 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Tennessee b. COUNTY Millington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6952 Navy Road d. STREET ADDRESS 7	
3. NAME OF DECEASED (Type or print) RUSSELL DUANE MC CRACKEN		4. DATE OF DEATH Month April Day 17 Year 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-17-24	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		9b. AGE (In years if UNDER 1 YEAR If UNDER 24 HRS last birthday) yrs. 37 Months 0 Days 0 Hours 0 Min. 0	
10a. KIND OF BUSINESS OR INDUSTRY U. S. Navy		10b. BIRTHPLACE (County & State, or foreign country) Michigan	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George MC CRACKEN		14. MOTHER'S MAIDEN NAME Muriel WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII-Korean		16. SOCIAL SECURITY NO 385-14-2237	
17. INFORMANT (W) Mrs. Dona C. McCracken, same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic sarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 197X			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 16, 1960 to April 17, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 17, 1961 , and that death occurred at 4AM , from the causes and on the date stated above.			
22a. SIGNATURE J. H. Miller		22b. DATE SIGNED 4-17-61	
22c. PHYSICIAN'S NAME (Type) J. H. MILLER, LT, MC, USNR		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 4-18-61		23b. DATE THEREOF 4-18-61	
23c. NAME OF CEMETERY OR CREMATORY Memphis National Cem.		23d. LOCATION (City, town or county) (State) Memphis Tenn.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		25a. REC'D BY REGISTRAR APR 19 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE	



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

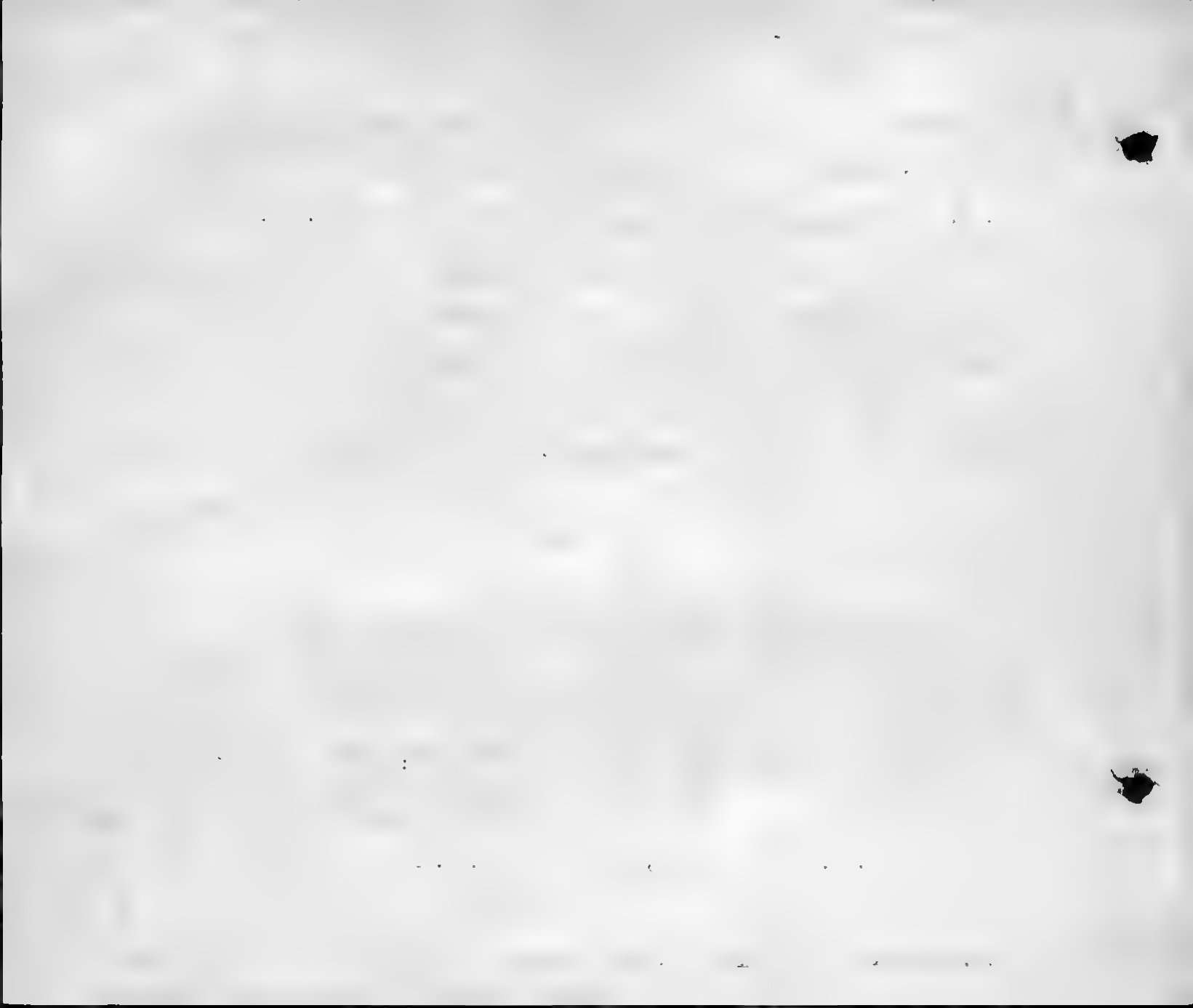
VR A15 (4)
15M 9/60

1
4522

3 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04513

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3601 Nichols Ave., S. E.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN b. 1 1/2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie Will MC MILLAN		4. DATE OF DEATH April 25 1961	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-23
10a. USUAL OCCUPATION, G. v. kind of work done during most of working life, even if retired. Secretary		11. BIRTHPLACE (County & State, or foreign country) Alabama	
13. FATHER'S NAME Curtis KINGRY		14. MOTHER'S MAIDEN NAME Ethie COOLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 422-16-3653 (H) Leon D. McMillan , same as #2 above	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary embolus 464X DUE TO (b) thrombophlebitis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) Acute Bacterial Endocarditis			
INTERVAL BETWEEN ONSET AND DEATH 12 hours Unknown duration			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from April 25, 1961 to April 25, 1961 , that (he) (we) last saw the deceased alive on April 25, 1961 , and that death occurred at 1:07 PM , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 4-25-61	
22c. PHYSICIAN'S NAME (Type) J. M. YOUNG, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shipment 4-26-61		23b. DATE THEREOF 4-26-61	
23c. NAME OF CEMETERY OR CREMATORY Cottonwood Cemetery		23d. LOCATION (City, town or county) (State) Cottonwood Ala.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 517 11th St., SE, WashDC		25a. REC'D BY REGISTRAR DATE APR 28 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

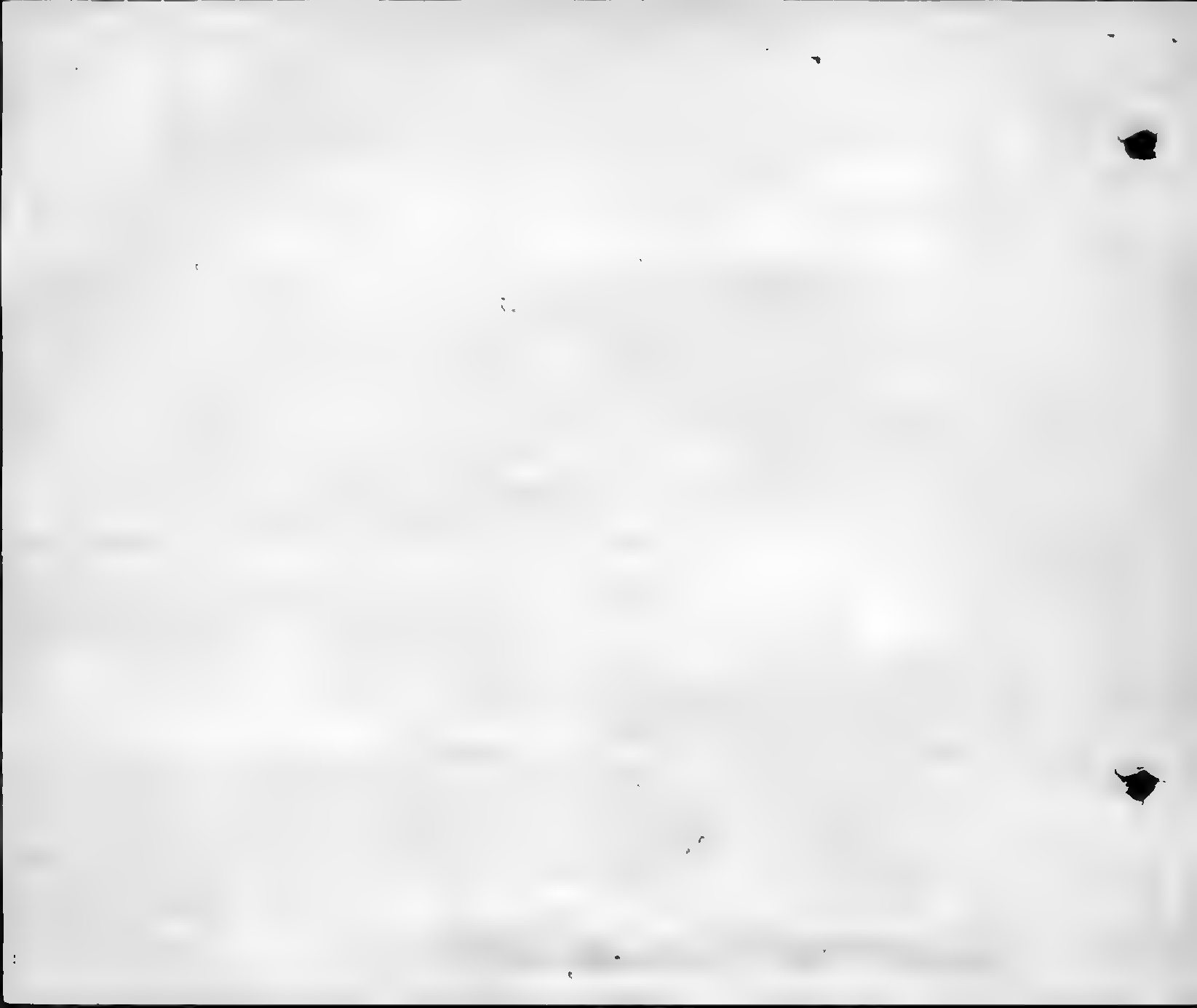
4523

CERTIFICATE OF DEATH

04514

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> MARYLAND</p> <p>b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u></p> <p>c. LENGTH OF STAY IN 1b <u>DOA</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u></p> <p>c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Rockville</u></p> <p>d. STREET ADDRESS <u>1274 Rockdale Dr.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>															
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Frank</u> Middle <u>—</u> Last <u>McMillen</u></p>		<p>4. DATE OF DEATH</p> <p>Month <u>April</u> Day <u>22</u> Year <u>1961</u></p>		<p>5. SEX <u>M</u></p>		<p>6. COLOR OR RACE <u>W</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>11/7/1896</u></p>		<p>9. AGE (In years last birthday) <u>64</u> yrs.</p>		<p>10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u></p>		<p>11. IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u></p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u></p>				<p>11. BIRTHPLACE (County & State, or foreign country) <u>New York</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>							
<p>13. FATHER'S NAME <u>James C. McMillen</u></p>				<p>14. MOTHER'S M maiden NAME <u>Ray</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch, dates of service) <u>Yes 1941-1944</u></p>				<p>16. SOCIAL SECURITY NO. <u>Abbie K. McMillen, same as above.</u></p>				<p>17. INFORMANT <u>Abbie K. McMillen, same as above.</u> Address <u>—</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cardiac arrest</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u></p> <p>(c) <u>—</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>—</u></p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u></p> <p><u>Several years</u></p>																			
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>															
<p>20c. TIME OF INJURY Month, Day, Year <u>19</u></p> <p>Hour a.m. <u>—</u> p.m. <u>—</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>							
<p>21. I certify that (I) (this hospital) attended the deceased from <u>August 1956</u> to <u>April 1961</u>, that (I) (we) last saw the deceased alive on <u>4/14</u> 1961, and that death occurred at <u>3:22</u> M, from the causes and on the date stated above.</p>																			
<p>22a. SIGNATURE <u>Jack Segal</u></p>				<p>22b. DATE SIGNED <u>4/22/61</u></p>				<p>22c. PHYSICIAN'S NAME (Type) <u>Jack Segal</u></p>				<p>22d. ADDRESS <u>5323 Connecticut Ave W.W. Wash. D.C.</u></p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>				<p>23b. DATE THEREOF <u>4/26/61</u></p>				<p>23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u></p>				<p>23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u></p>							
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u></p>				<p>25. REC'D BY REGISTRAR <u>APR 25 '61</u></p>				<p>25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u></p>				<p>25c. ADDRESS <u>1331 E. Montgomery Avenue Rockville, Maryland</u></p>							

VR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04515

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY 2 yr
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 222 Dale Dr.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md. b. COUNTY monty
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 1222 Dale Dr.

3. NAME OF DECEASED (Type or print) Charles Daniel Meyer
First Middle Last
4. DATE OF DEATH Apr 2 1961
Month Day Year

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH 1-25-1880
WIDOWED ☐ DIVORCED ☐ 81 yr.
9. AGE (In years last birthday) 81 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant 10b. KIND OF BUSINESS OR INDUSTRY N.S. Gov. 11. BIRTHPLACE (State or foreign country) S.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Meyer 14. MOTHER'S MAIDEN NAME Susan Hudson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Martha Meyer (wife) Address Item 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism
153.8 DUE TO (b) C.A. of colon - post operative
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
Diabetic Mellitus 20 yr
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

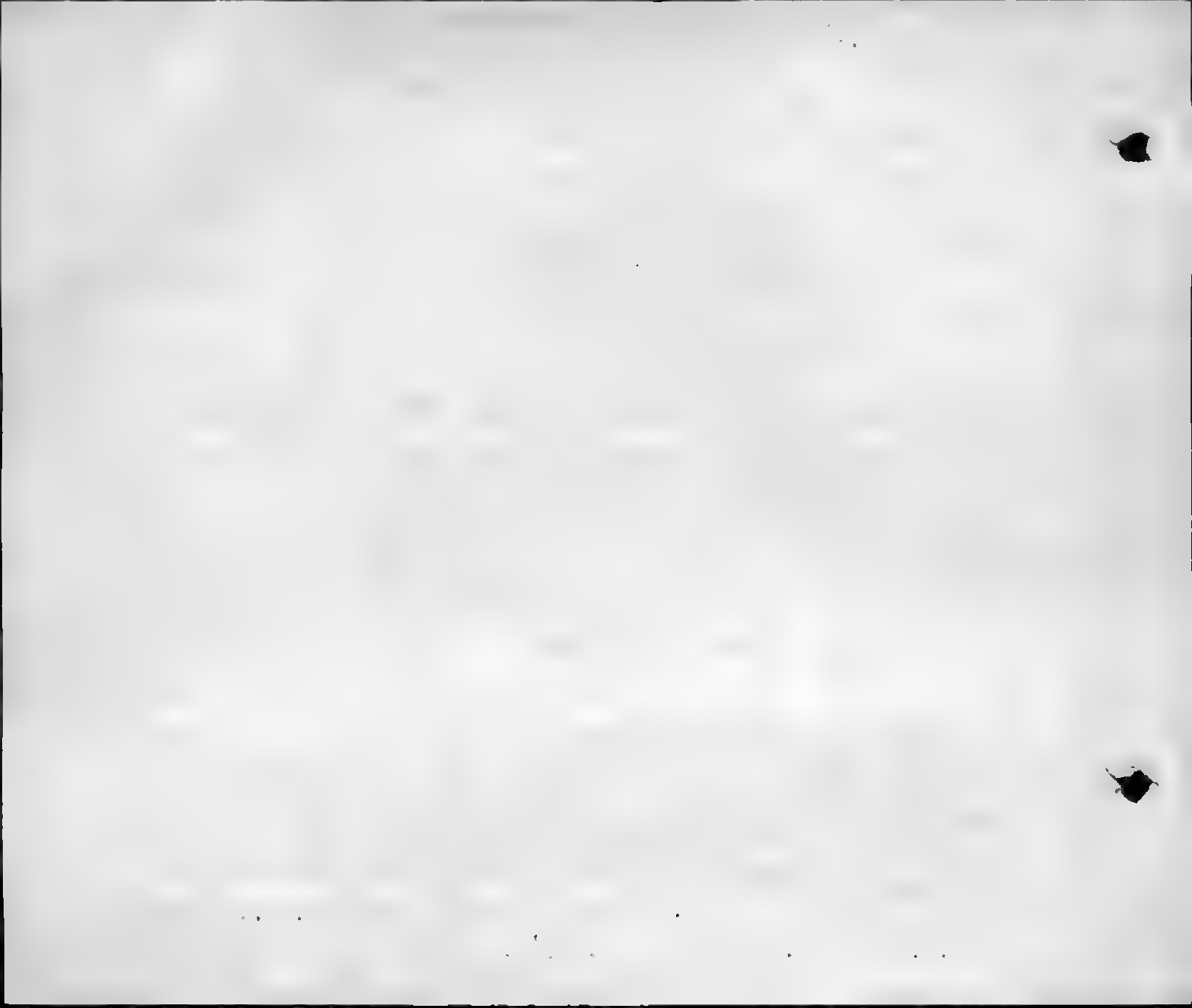
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

SIGNATURE Frank J. Broschert M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J. Broschert ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 4-2-61
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State)
Cremation 4/2/61 Ft. Lincoln Crematory Pr. Geo. Co., Maryland

23. FUNERAL DIRECTOR ADDRESS Wash, D.C. 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
The S.H.Hines Co., 2901 14th St. N.W., DATE APR 4 '61 Arthur S. Hines

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

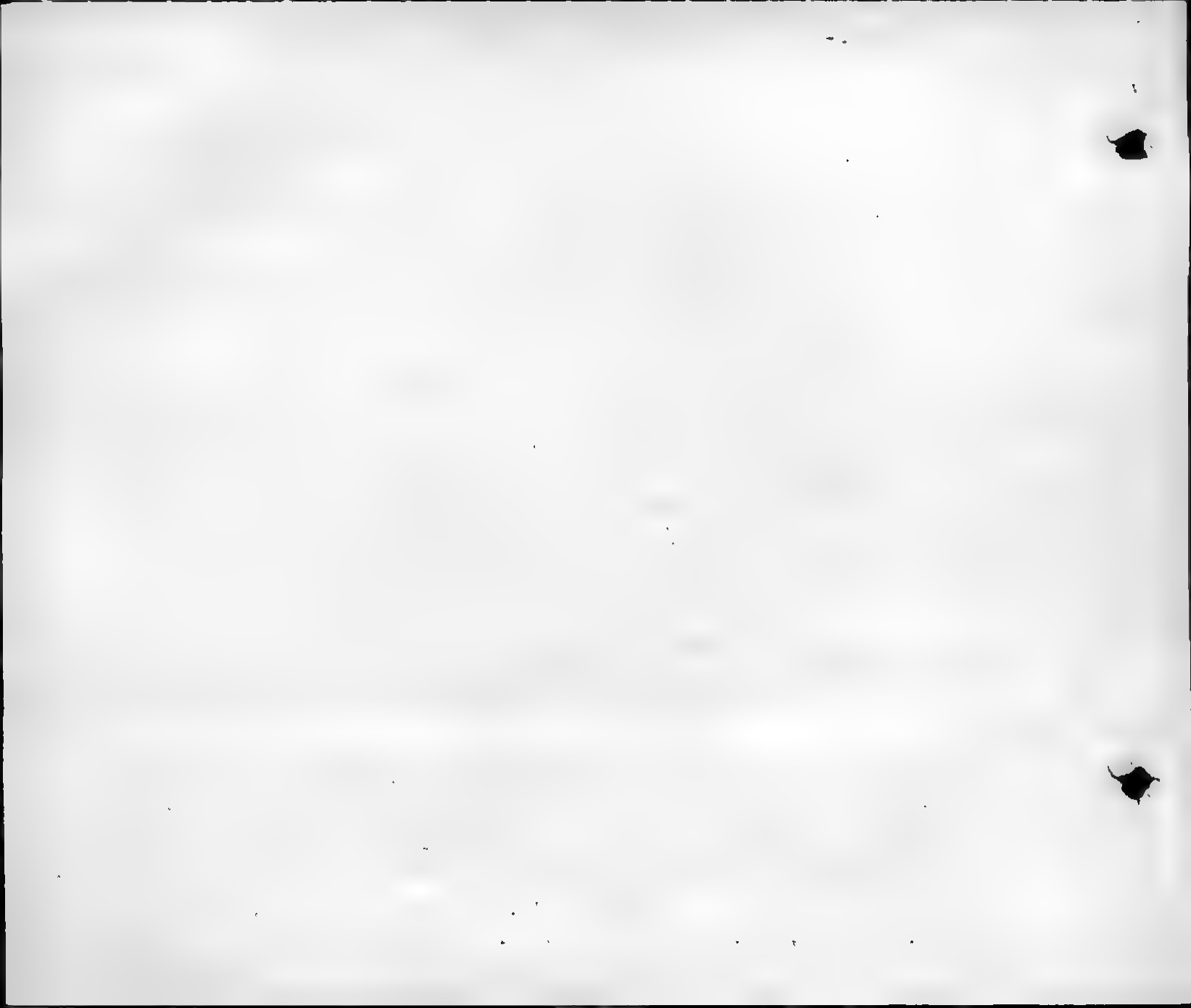
4525
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04516

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN lb <u>7yr. 7mo.</u> d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1321 Benwood Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Margaret Woods Meryl</u>		4. DATE OF DEATH Month Day Year <u>April 12 1961</u>	
5 SEX <u>Fem</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1912</u>
9 AGE (In years last birthday) <u>49</u> yrs		10 UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>LA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW Van Woods</u>		14 MOTHER'S MAIDEN NAME <u>WILLOMENIA KELLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Vanada J. Meryl</u>		Address <u>Act. 208 2221 Blue Ridge Rd. Wheaton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation (Laryngospasm)</u> DUE TO <u>Multiple Sclerosis - progressing +</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Terminal (Laryngospasm-Terminal)</u> (b) <u>8 yrs</u> (c) <u>8 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Aug 28, 1953</u> to <u>April 12 1961</u> , that (I) (we) last saw the deceased alive on <u>March 28 1961</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above			
22a SIGNATURE <u>John B Ziegler</u>		22b DATE SIGNED <u>12 April 61</u>	
22c PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>		22d ADDRESS <u>OLNEY MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>4/14/61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>		23d LOCATION (City town or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24a REC'D BY REGISTRAR <u>Raymond E. Fupat</u>		24b REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
25a DATE <u>APR 19 '61</u>		25b REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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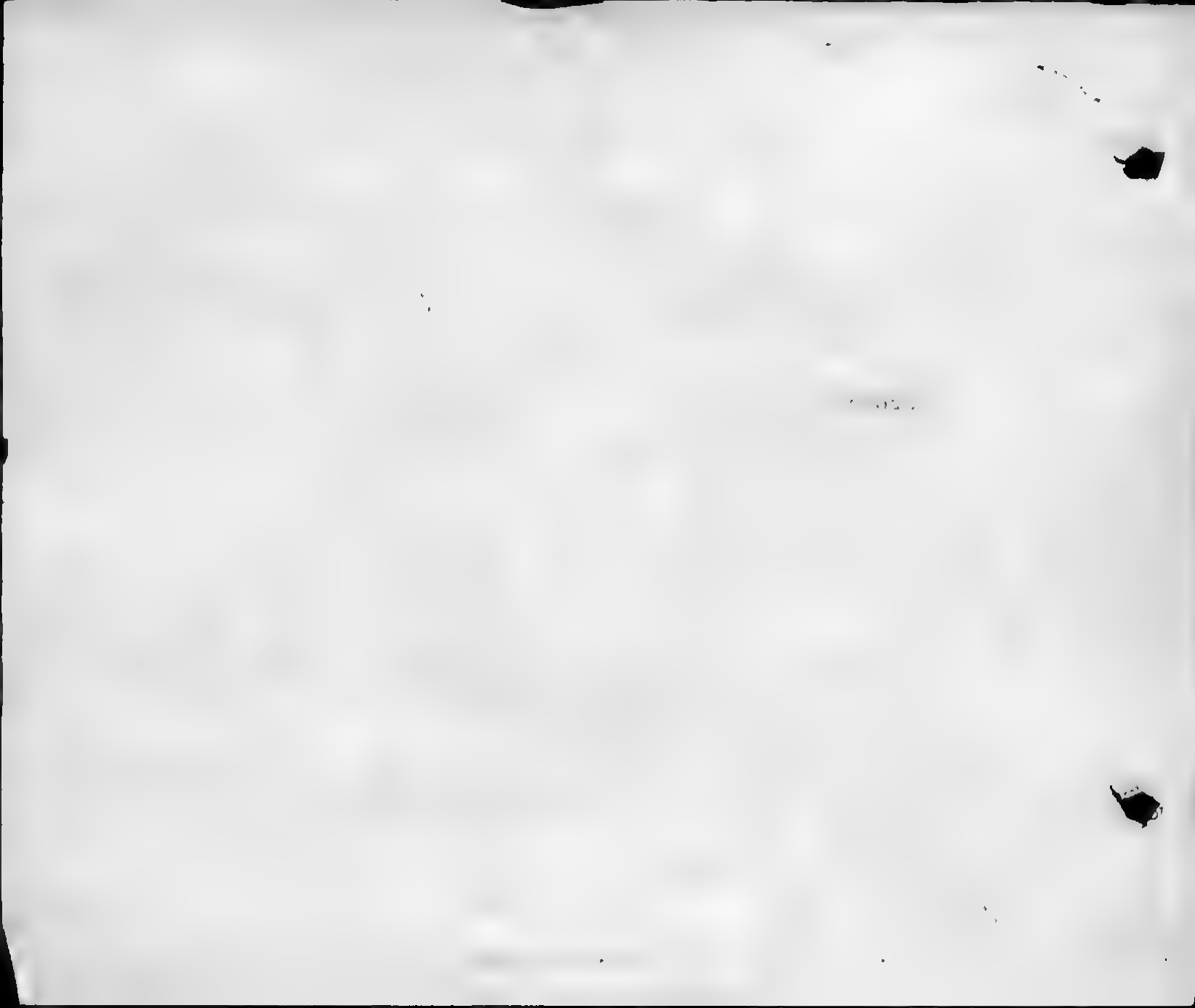
TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

4520
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04517

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>14 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>1880 Ridge Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARTHA M. Miller</u>		4. DATE OF DEATH <u>April 3 1961</u>		5. AGE (in years last birthday) <u>86 yrs.</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 16, 1875</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Jerome Fridinger</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hughes</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT <u>Hertude Hake (daughter)</u> Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, posterior</u> DUE TO (b) <u>Arteriosclerosis, severe</u> DUE TO (c) <u>None</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema, Left Internal Capsule</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , to <u>April 3</u> , 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 3</u> , 19 <u>61</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Jack Crwell</u>		22b. DATE SIGNED <u>4/3/61</u>		22c. PHYSICIAN'S NAME (Type) <u>JACK CRWELL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>	
23d. LOCATION (City, town or county) <u>Martinsburg, West Virginia</u>		23e. REC'D BY REGISTRAR <u>Arthur S. Hume</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Hume</u>		24b. ADDRESS <u>Bethesda, Maryland</u>		24c. DATE <u>APR 10 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

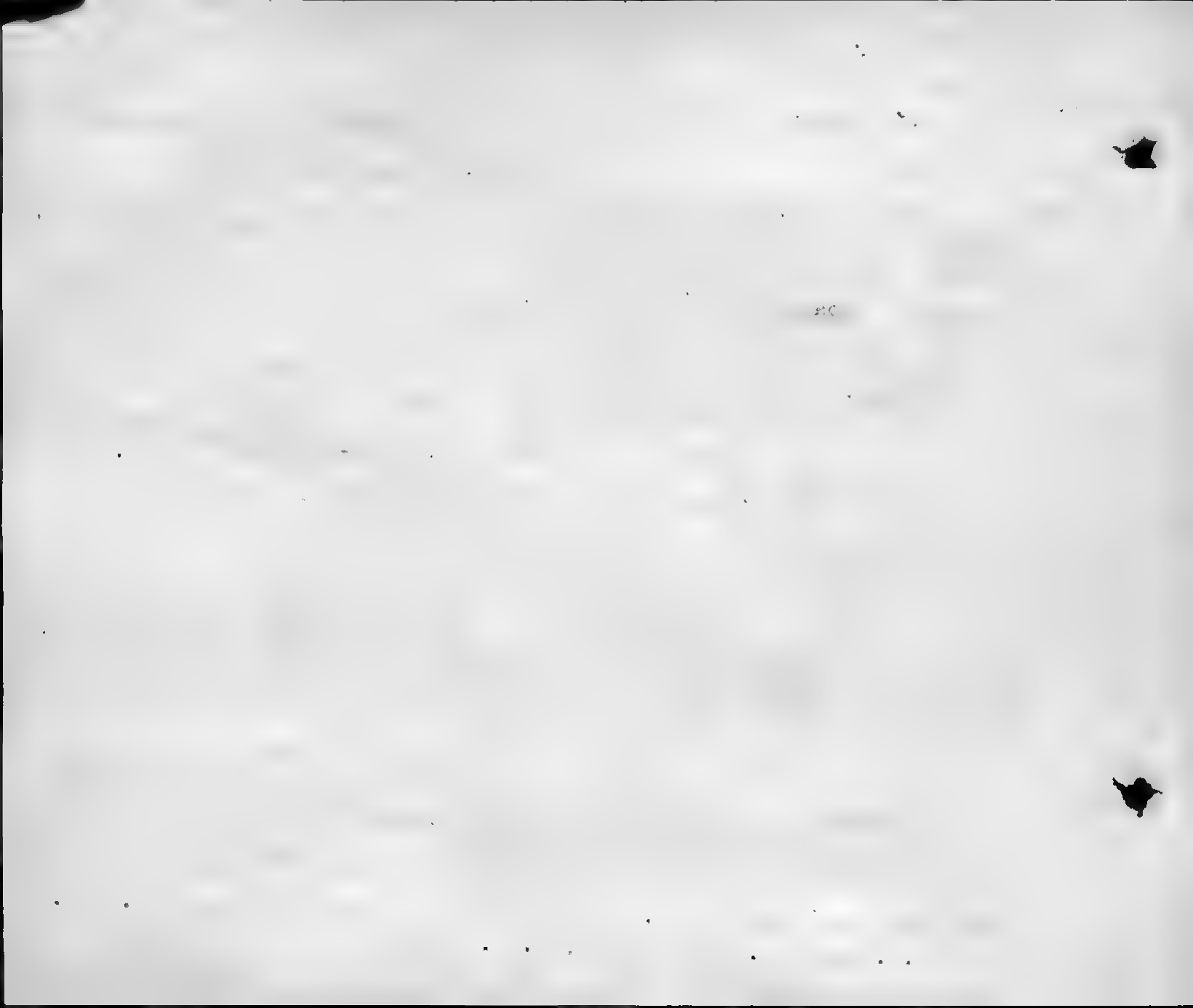
VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4527									
04518									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11114 Dewey Road					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 11114 Dewey Road				
3. NAME OF DECEASED (Type or print) SUE					4. DATE OF DEATH MITOMA 4 17 1961				
5. SEX female 6. COLOR OR RACE Japanese 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 12/25/91 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					11. BIRTHPLACE (County & State or foreign country) FUKUOKA JAPAN 12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Izaya Takagi					14. MOTHER'S MAIDEN NAME Kiyo Kido				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. none 17. INFORMANT Poshicho Mitoma - Kensington, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (b) 3 years (a), stating the underlying cause last, (c) INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 4:17 p.m. 1961					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9P.M. 20f. (City or town) (County) (State) PRINCE GEORGES CO. MD.				
21. I certify that (I) (this hospital) attended the deceased from JAN. 10, 1956 to APRIL 17, 1961 , that (I) (no) last saw the deceased alive on 4/17 , 1961, and that death occurred at 9P.M. from the causes and on the date stated above									
22a. SIGNATURE John E. Everett					22b. DATE SIGNED APR 19 '61				
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT					22d. ADDRESS 9400 CONN. AVE KENSINGTON MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					23b. DATE THEREOF 4/21/61				
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory					23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.				
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.					25a. REC'D BY REGISTRAR Washington, D. C. 25b. REGISTRAR'S SIGNATURE Arthur S. Hines				



TO BE RETURNED TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician after this certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

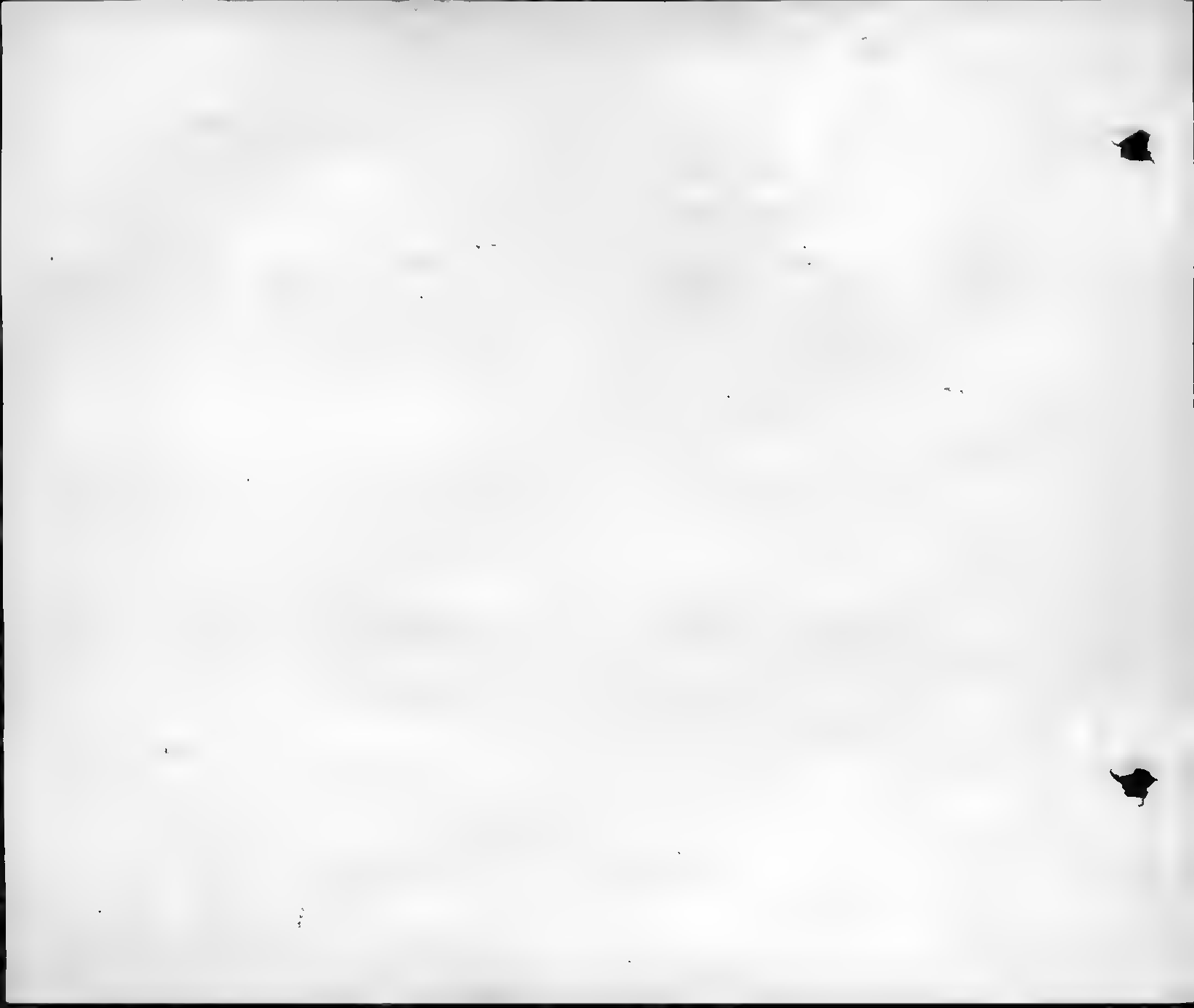
VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4528

04519

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillandale, Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>23 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10,306 Nagle Road</u>		e. STREET ADDRESS <u>10,306 Nagle Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Wallace</u> Middle <u>Nevin</u> Last <u>Mook</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1910</u>
9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR Months <u>50</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M.D.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ambridge, Penn.</u>		12. C ITIZEN OF WHAT COUNTRY? <u>U.S. of America</u>	
13. FATHER'S NAME <u>Edward Dennis Mook</u>		14. MOTHER'S MAIDEN NAME <u>Edna Lillian Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>READ N. CALVERT, M.D.</u>		Address <u>909 Pershing Dr., Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Plasma cell Myeloma</u> <u>LOSS</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Boney Metastasis with Pathological Fractures.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month. Day. Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>56</u> to <u>April 13</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>April 12, 1961</u> , and that death occurred at <u>7:24 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Read N. Calvert, M.D.</u>		22b. DATE SIGNED <u>April 13, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Read N. Calvert, M.D.</u>		22d. ADDRESS <u>909 Pershing Dr., Suite 107, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 17, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George's Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kneass</u>	
ADDRESS <u>254 Carroll St NW</u>		DATE <u>APR 18 '61</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac c. LENGTH OF STAY IN 1b 18 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) White Water - Potomac River		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoorland Hills d. STREET ADDRESS 5236 Duvall Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Caldwell Last Moore		4. DATE OF DEATH Month April Day 22 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/14
9. AGE (In years last birthday) 48 4/6 yrs.		IF UNDER 1 YEAR Months 4 Days 8	IF UNDER 24 HRS. Hours 4 Min. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hiram S. Caldwell	
14. MOTHER'S MAIDEN NAME Nellie McCormick		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no..	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Thornton B. Moore-Husband-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.8 DUE TO drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Unknown-Dissappeared at Seneca, Md. 3/29/61	
20c. TIME OF INJURY Month, Day, Year 3/29 1961 Hour ? a. m. ? p. m. ?		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River		20f. (City or town) (County) (State) Seneca, Montgomery, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4/22/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/22/61	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Switland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Dones		24a. REC'D BY REGISTRAR DATE APR 25 '61	
ADDRESS 1756 P. Ave. N. J.		24b. REGISTRAR'S SIGNATURE William S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4530
04521
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Jan & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if not last one; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>48 Philadelphia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Josephine</u> First Middle Last 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1961</u> 8. DATE OF BIRTH <u>3-12-81</u> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 13. FATHER'S NAME <u>Isaac Watson</u>		11. BIRTHPLACE (Country, State or foreign country) <u>Delaware</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> 16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Daughter - (Mrs Betty Hurley)</u> Address <u>6425-17th St NW - DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434.1 CARDIAC ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>BRONCHOPNEUMONIA & ANEMIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNDETERMINED</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>MARKED CAEXIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-11-61</u> , 19 <u>61</u> , to <u>4-13-61</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>4-13-61</u> , 19 <u>61</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Morrill C. Quinnam</u> M.D.		22b. DATE SIGNED <u>4-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morrill C. Quinnam</u>		22d. ADDRESS <u>7600 Carroll Ave. Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>cremation</u>	<u>4/15/61</u>	<u>Pt. Lincoln Crematory</u>	<u>Prince Georges, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. H. Harris</u>		25a. REC'D BY REGISTRAR <u>WASH 4, D.C.</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

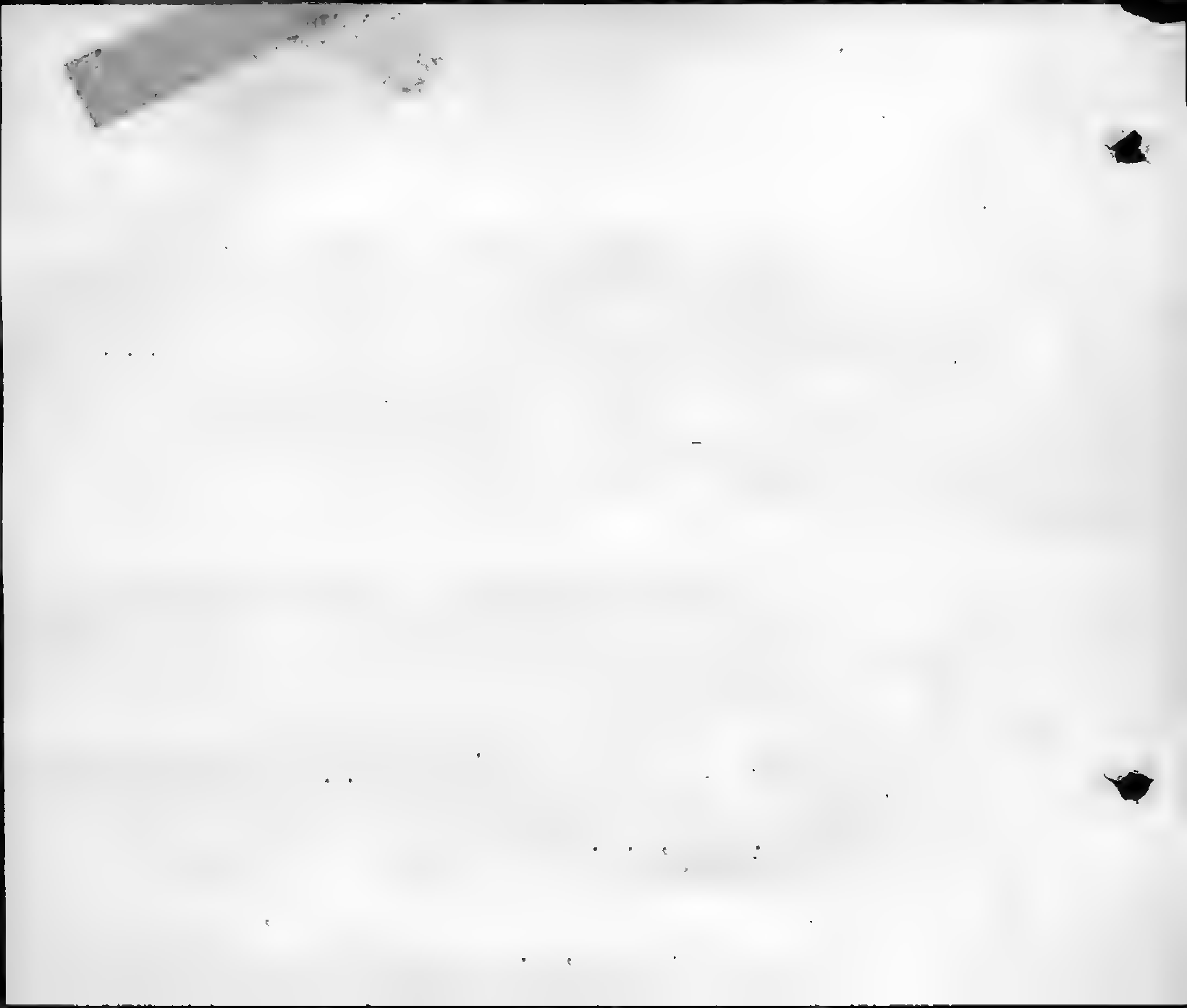
VR A15 (4)
15M 9/59

1
4531

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04522

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 7 hrs; 5 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Res. dence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Eureka Last Morgan		4. DATE OF DEATH Month April Day 14 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1873
9. AGE (in years last birthday) 87		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry L. Rucker		14. MOTHER'S MAIDEN NAME Susan Anis Siler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5705 intestinal obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 9 19 61 , to April 14 19 61 , that (I) (we) last saw the deceased alive on April 14 19 61 and that death occurred at 7/35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John P. Martin		22b. DATE SIGNED 4/14/61	
22c. PHYSICIAN'S NAME (Type) John P. Martin, M. D.		22d. ADDRESS Sandy Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Indiana	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR APR 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE APR 17 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

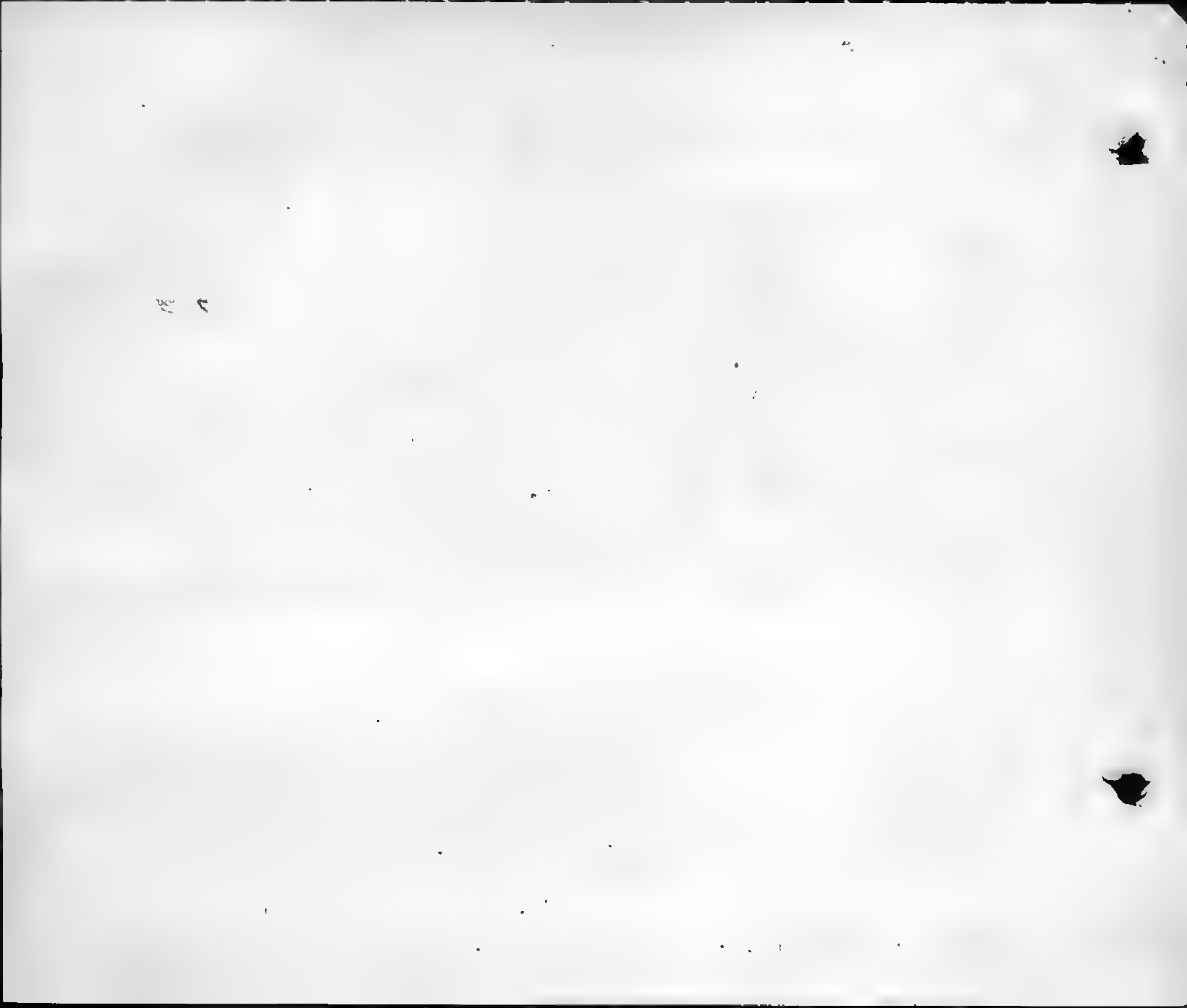
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4532

04523

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Univ. Hosp.</u>				d. STREET ADDRESS <u>110005 Sembrook</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Nelson</u> Last <u>Moulden</u>				4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1961</u>			
5 SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 3, 1876</u>	
9. AGE (In years last birthday) <u>84 yrs</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>master machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Rockville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eliah</u> <u>Stacy Moulden</u>				14. MOTHER'S MAIDEN NAME <u>Martha unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Spanish American 216-30-3887</u>		17. INFORMANT Address <u>Silver Spring, Md.</u> <u>Mrs. Mary Van Wert 10005 Sembrook</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage with left hemiplegia</u> 3 days (b) <u>Chronic degenerated myocarditis with</u> 4 yrs. (c) <u>auricular fibrillation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>/</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>/</u>		20f. (City or town) (County) (State) <u>/</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> <u>1945</u> to <u>4/5</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>4/5</u> <u>1961</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Howard T. Morse, M.D.</u>				22b. DATE <u>5 GNED</u>			
22c. PHYSICIAN'S NAME (Type, <u>Howard T. Morse, M.D.</u>)				22d. ADDRESS <u>7030 Carroll Ave, Takoma Park-12, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u>				25a. REC'D BY REGISTRAR <u>DATE APR 11 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Almond A. ...</u>				25c. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

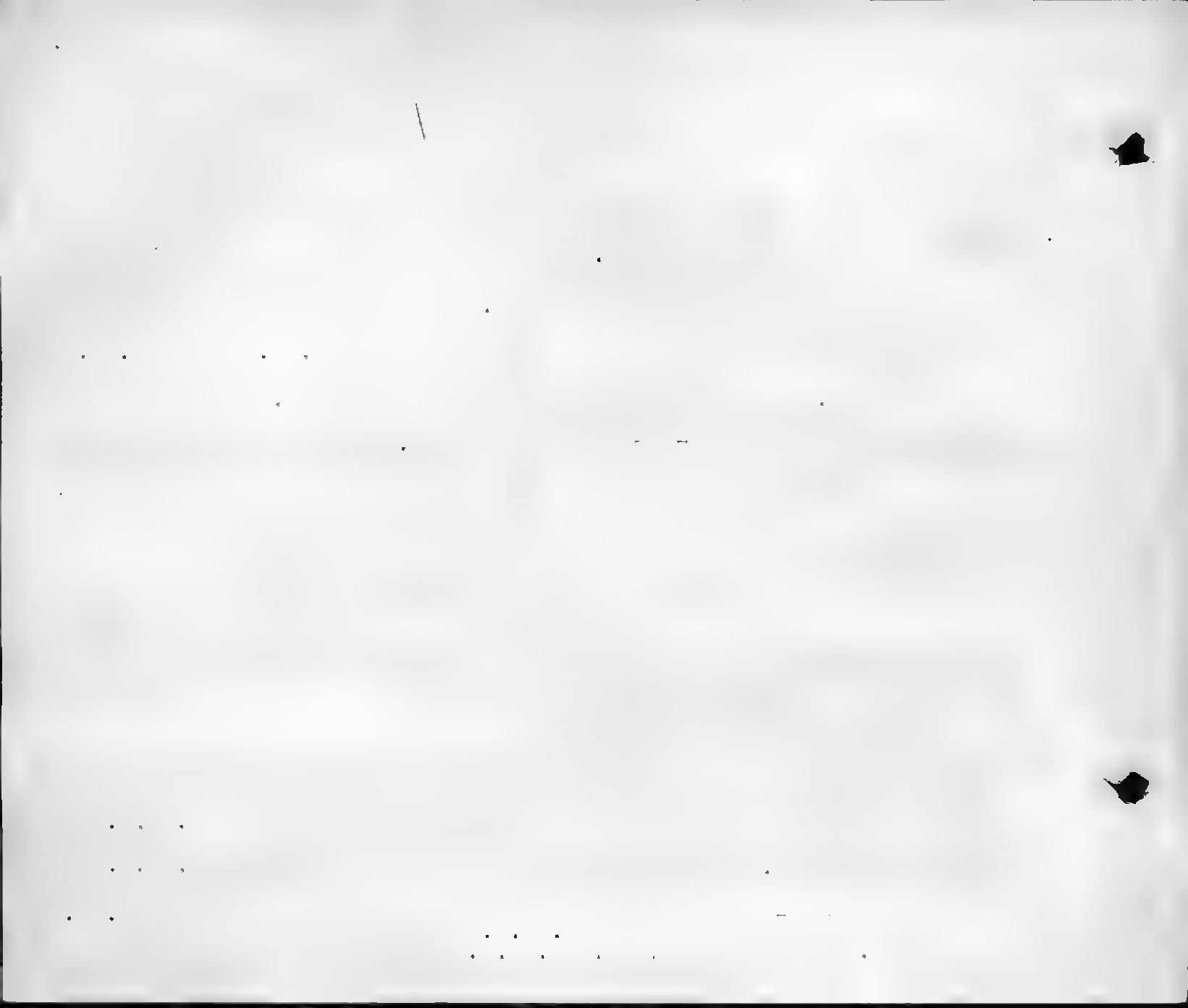
Reg. Dist. No.

04524

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>C. E. VY CLASE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CHEVY CHASE</u>	
c. LENGTH OF STAY IN 1b <u>20 YEARS</u>		d. STREET ADDRESS <u>3585 WOODBINE STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3585 WOODBINE STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALLAN C. LILLY</u>		4. DATE OF DEATH Month Day Year <u>APRIL 17 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1936</u>
9. AGE (In years lost birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIRE SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HUGH A. ERNST</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA E. HANTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-03-2379</u>	
17. INFORMANT <u>FRANCIS J. LILLY</u>		Address <u>S. 300 S. 12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage of brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>primary cerebral hemorrhage of right side</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>7 months</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/29, 1944</u> to <u>Apr 17, 1961</u> , that I last saw the deceased alive on <u>Apr 16, 1961</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3100 CONNELLVILLE RD. BALTIMORE, M.D.</u> DATE SIGNED <u>4/17/61</u>			
ACTUAL SIGNATURE <u>Joan V. Dolan</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN V. LILLY</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-10-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821 14TH. ST. N.W.</u>		24a. REC'D BY REGISTRAR <u>APR 18 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. House</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

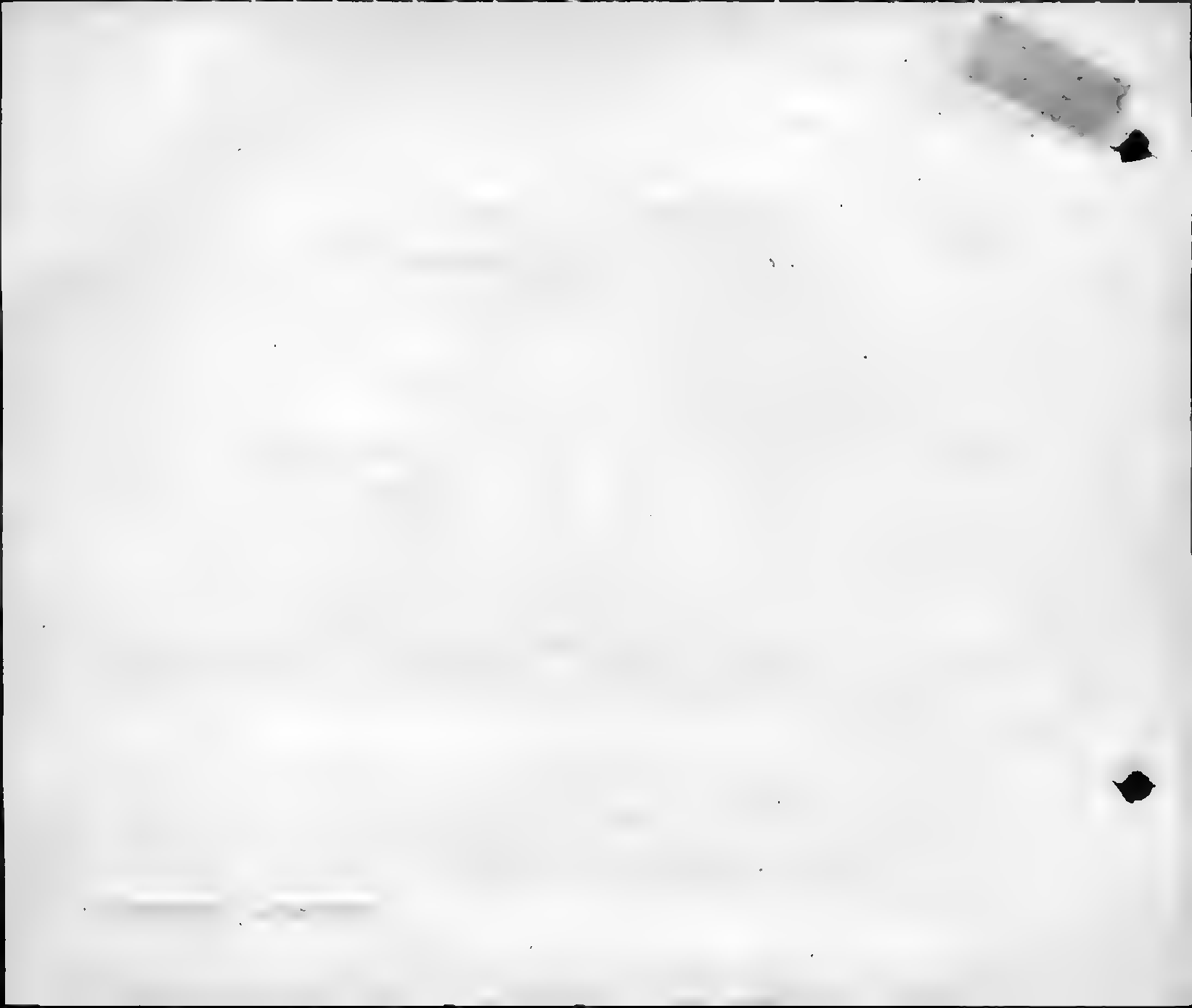


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04525

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <input checked="" type="checkbox"/> b. COUNTY WASHINGTON, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 33 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital		e. STREET ADDRESS 3721 49th ST. N.W.	
3 NAME OF DECEASED (Type or print) PERMELIA CATHRYN MUMFORD		4. DATE OF DEATH 3:35 PM April 25 1961	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT. 22 1906
9. AGE (In years lost birthday) 54 yrs		IF UNDER 1 YEAR: Months 54 Days 54 Hours 54 Min. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY BRANFORD CONNECTICUT	
11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT P. STEVENS		14. MOTHER'S MAIDEN NAME CATHARINE Callinan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO. NONE	
17 INFORMANT MR. L. O. MUMFORD (husband)		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Coma DUE TO Portal Cirrhosis Conditions if any, which gave rise to immediate cause (a), stating the under lying cause last (b) 2 months DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year June 19 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 1956 to April 25, 1961 that (I) (we) last saw the deceased alive on April 25, 1961 , and that death occurred at 3:35 PM , from the causes and on the date stated above			
22a. SIGNATURE Joseph H. Watson		22b. DATE SIGNED 4/25/61	
22c. PHYSICIAN'S NAME (Type) Joseph H. Watson		22d. ADDRESS 3201 Wisconsin Ave. Wash D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 4/26/61		23b. DATE THEREOF 4/26/61	
23c. NAME OF CEMETERY OR CREMATORY East Lawn Cemetery		23d. LOCATION (City, town, or county) (State) East Haven, Connecticut	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR APR 27 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hays	



1
FOR STATE
HEALTH DEPT.

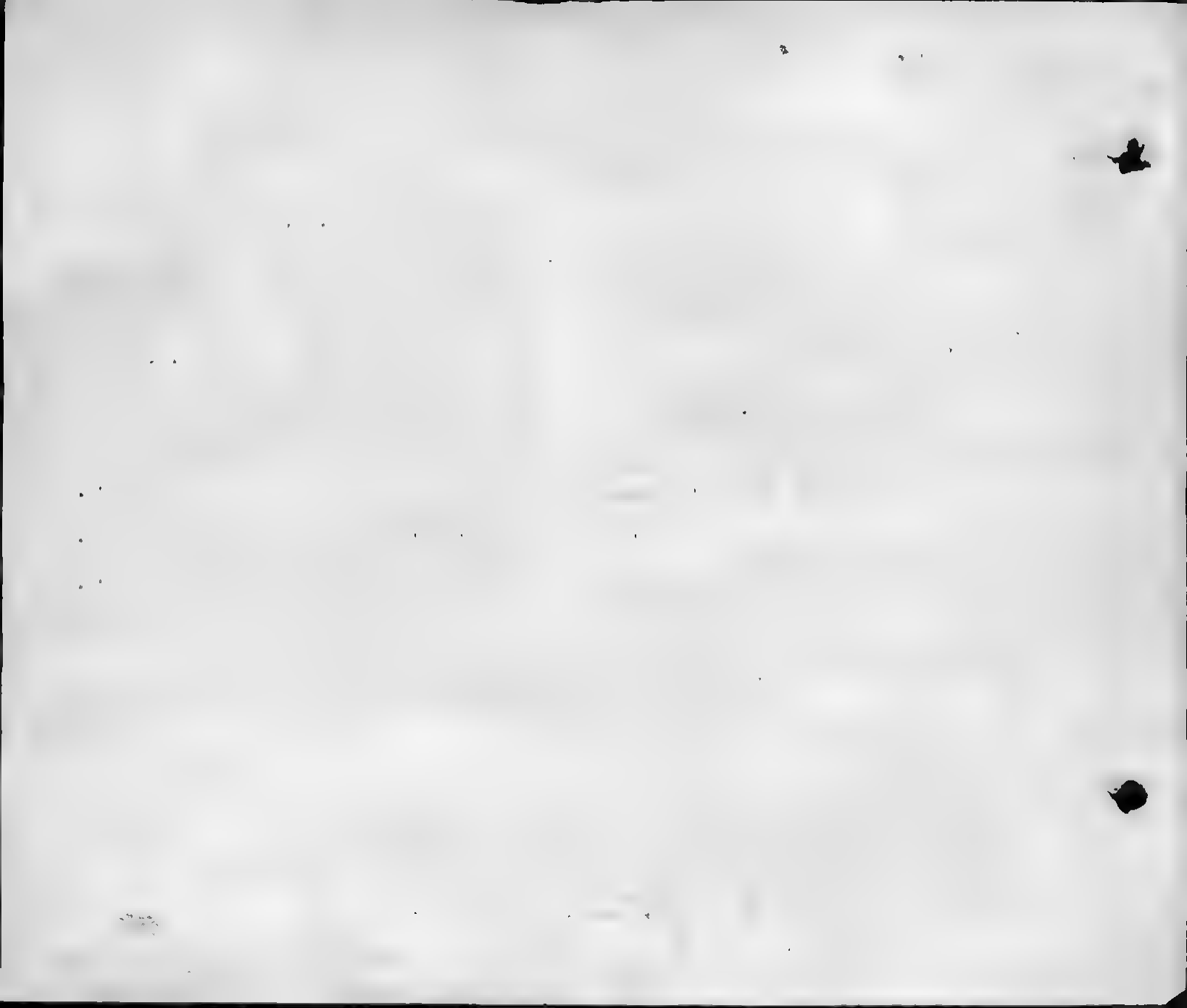
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY	
4535		Montgomery		4 hrs		D.C.		45830	
3. NAME OF DECEASED (Type or print)		6. COLOR OR RACE		7. MARIED		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Dorothy		Col		NEVER MARRIED		3/21/26		35 yrs.	
5. SEX		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
F		Housewife				WASH D C		U.S.A	
13. FATHER'S NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
William H. Brown						Mildred Jones			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED?		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible shock		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		823X		Driver of car which left highway + struck tree		4-25 1961	
DUE TO				Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.		Fractured cervical vertebrae		5 hrs.	
DUE TO						Automobile accident		5 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				Pregnancy (7 Mos)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Burial		Apr 29 61		Mt Olivet Cemetery		DC	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. DATE		24d. ADDRESS (Street, city, town, or country)	
Haller, E. Hunter Wash, DC		4/29/61		Arthur S. Kenna		4-26-61			

MAY 2 '61

Arthur S. Kenna



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4536
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04526

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>HIV</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SAN. HOSP</u>		d. STREET ADDRESS <u>628 HAMILTON ST. NW</u>	
3. NAME OF DECEASED (Type or print) <u>CLIFTON CLAY NIBLOCK</u>		4. DATE OF DEATH <u>April 14 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1894</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>14</u> Hours <u>14</u> Min <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired DC Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANKLIN NIBLOCK</u>		14. MOTHER'S MAIDEN NAME <u>FRANCE RENSNAW</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO <u>WW 1 am</u>	
17. INFORMANT <u>Louise N. Niblock</u>		Address <u>628 Hamilton NW</u>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>93X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>93X</u> DUE TO (c) <u>93X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1960</u> to <u>4/14/61</u> , that I last saw the deceased alive on <u>4/12/61</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald Nelson</u>		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Silver Spring, Md</u>	
DATE SIGNED <u>4/14/61</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 18, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neaf Funerals Home</u>		ADDRESS <u>4812 Hagerman NW</u>	
24a. REC'D BY REGISTRAR <u>APR 19 61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

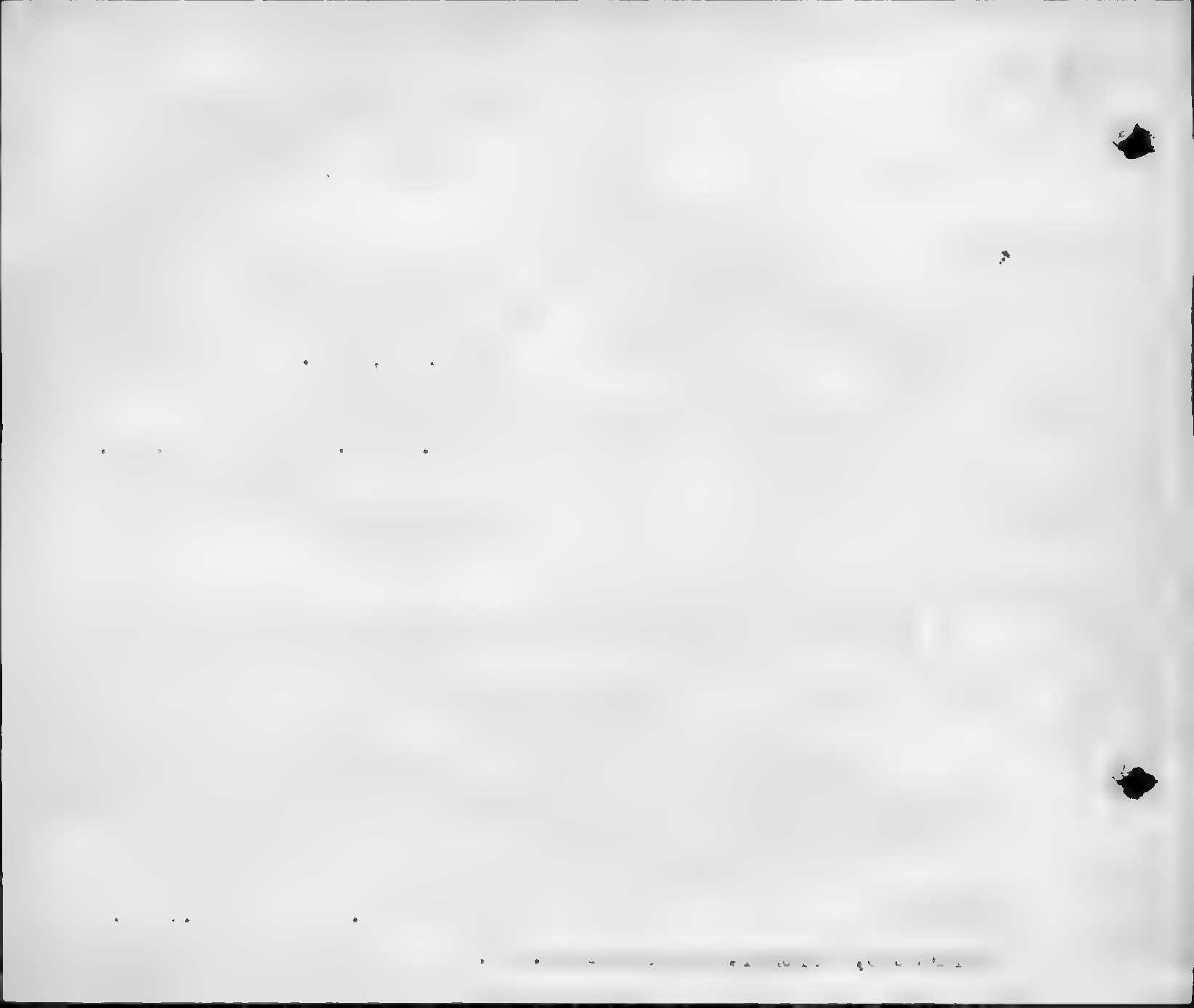
CERTIFICATE OF DEATH

04527

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boys (Rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boys (Rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED * (Type or print) First <u>Oliver</u> Middle <u>Nicholson</u> Last <u>Nicholson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11-1873</u>
9. AGE (in years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gardening</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montg. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Hamilton Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Delilah Andrews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Arthur R. Tapp.</u>		Address <u>Washington, D C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Disease (CVA)</u>			
31X DUE TO (b) <u>Generalized Arteriosclerosis</u>			
DUE TO (c) <u>Lower Gastrointestinal Hemorrhaging Chronic course incl.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 11, 1954</u> to <u>17 Apr., 1961</u> , that (I) (we) last saw the deceased alive on <u>16 Apr. 1961</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon M. Smith</u>		22b. DATE SIGNED <u>18 Apr 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon M. Smith</u>		22d. ADDRESS <u>Barnesville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-20-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Methodist Ch.</u>		23d. LOCATION (City, town or county) (State) <u>Hyattstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		25a. REC'D BY REGISTRAR <u>APR 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



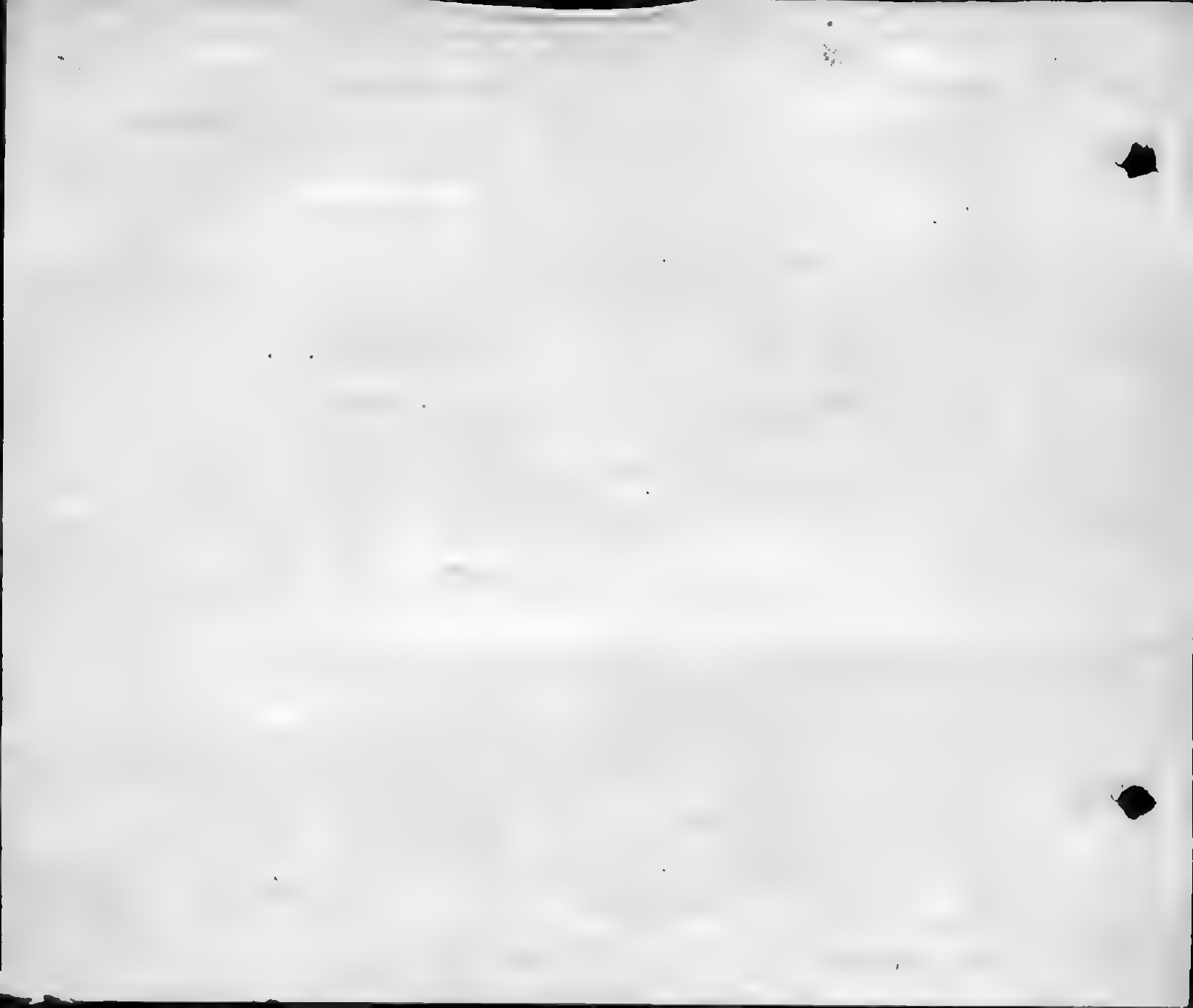
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 shall be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4538											
04528											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fairland Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1615 Flora Lane						
3. NAME OF DECEASED (Type or print) Rose E. Nicholson					4. DATE OF DEATH 4 28 19 61		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/21/1897		9. AGE (In years last birthday) 63 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Moop					14. MOTHER'S MAIDEN NAME Mary A. Langley					Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis										2 weeks 3 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb 1 to April 28 , 19 61 , that (I) (we) last saw the deceased alive on 4/26 19 61 , and that death occurred at 8:15 M, from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE John E. Everett					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT					22d. ADDRESS 9400 Conn. Ave, Kensington						
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF May 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland Md					
24. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee					ADDRESS 300-4 1st NE Wash. D.C.		25a. REC'D BY REGISTRAR MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kinn		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4539

04529

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Silver Spring**
c. LENGTH OF STAY IN IT **3 weeks**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **123 Lexington Drive**

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE **New Jersey** b. COUNTY **Union**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Pine Lake Park**
d. STREET ADDRESS **Box 568 - M**

3. NAME OF DECEASED (Type or print)
First **Anna** Middle **Mary** Last **Nittoli**

4. DATE OF DEATH
Month **April** Day **2** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **October 20, 1890** 9. AGE (In years last birthday) **70 yrs.** IF UNDER 1 YEAR Months **5** Days **12** IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Own home** 11. BIRTHPLACE (County & State, or foreign country) **Italy** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Peter Araneo** 14. MOTHER'S MAIDEN NAME **Rose Mary unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO. **NONE** 17. INFORMANT **Chester A. Nittoli** Address **Box 568 m, Pine Lake Park**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Carcinomatosis, primary left breast**
DUE TO (b) **170X**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) **5 yrs.**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **19** 20d. INJURY OCCURRED When at work ☐ Not at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **Mar - 4 1961** to **April 2, 1961**, that (I) (we) last saw the deceased alive on **Mar - 31 1961**, and that death occurred at **1430 PM**, from the causes and on the date stated above.

22a. SIGNATURE **A. L. Thibadeau** M.D. 22b. DATE SIGNED **APR 7 '61**

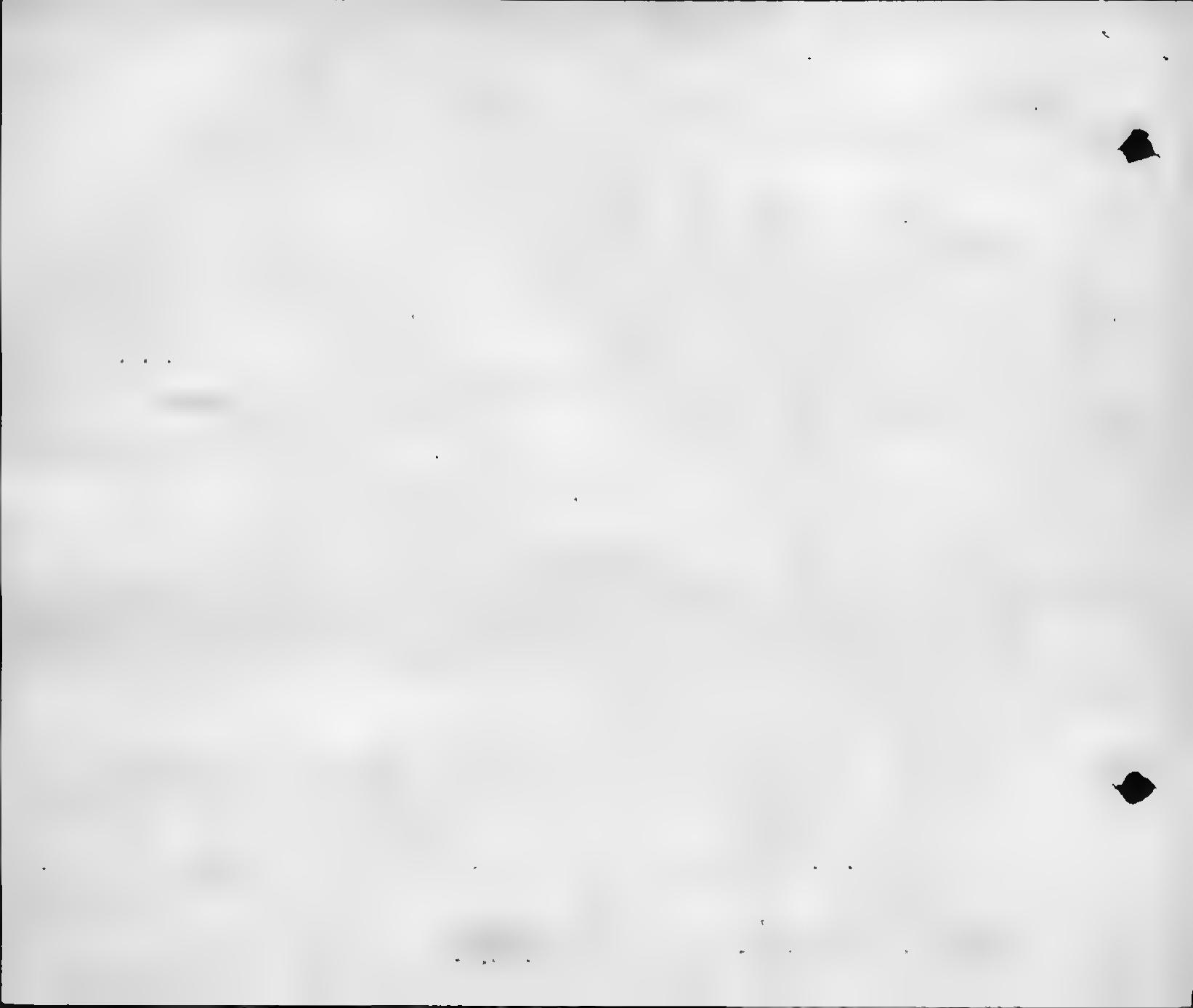
22c. PHYSICIAN'S NAME (Type) **A. L. Thibadeau** 22d. ADDRESS **10,111 Colesville Rd, Silver Spring, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **April 6, 1961** 23c. NAME OF CEMETERY OR CREMATORY **Hollywood Cemetery** 23d. LOCATION (City, town or county) (State) **Union County New Jersey**

24. FUNERAL DIRECTOR'S SIGNATURE **Raymond A. Jirka** ADDRESS **Silver Spring** 25. REGISTRAR'S SIGNATURE **A. J. L. Kraus**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



V5. A15ME
5M 7/59

Circling S. Crane

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1.
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04581

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, it should be executed as soon as possible. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp. Burnt Mills, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. STREET ADDRESS 915 McCENEY AVENUE

3. NAME OF DECEASED (Type or print) Bernard GEORGE Ostmann
First Middle Last

4. DATE OF DEATH 4 21 1961
Month Day Year

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 6-15-02
WIDOWED ☐ DIVORCED ☐ yrs. Months Days Hours Min.

9. AGE (in years) 58 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer
11. BIRTHPLACE (State or foreign country) Dudley, Jones, Moroney & Ostmann Co. D C 12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Anton Ostmann 14. MOTHER'S MAIDEN NAME Elizabeth Nolte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 213-38-2252 17. INFORMANT Mrs Irene Ostmann Address Same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Vascular accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found collapsed in bed.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous C.V.A. about 2 yrs ago

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Bloesch M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED April 21-61

EXAMINER'S NAME (Type) FRANK J. Bloesch Address (Street, c'ty, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 4/24/61 22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY 22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR WERNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR APR 25 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Hume



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

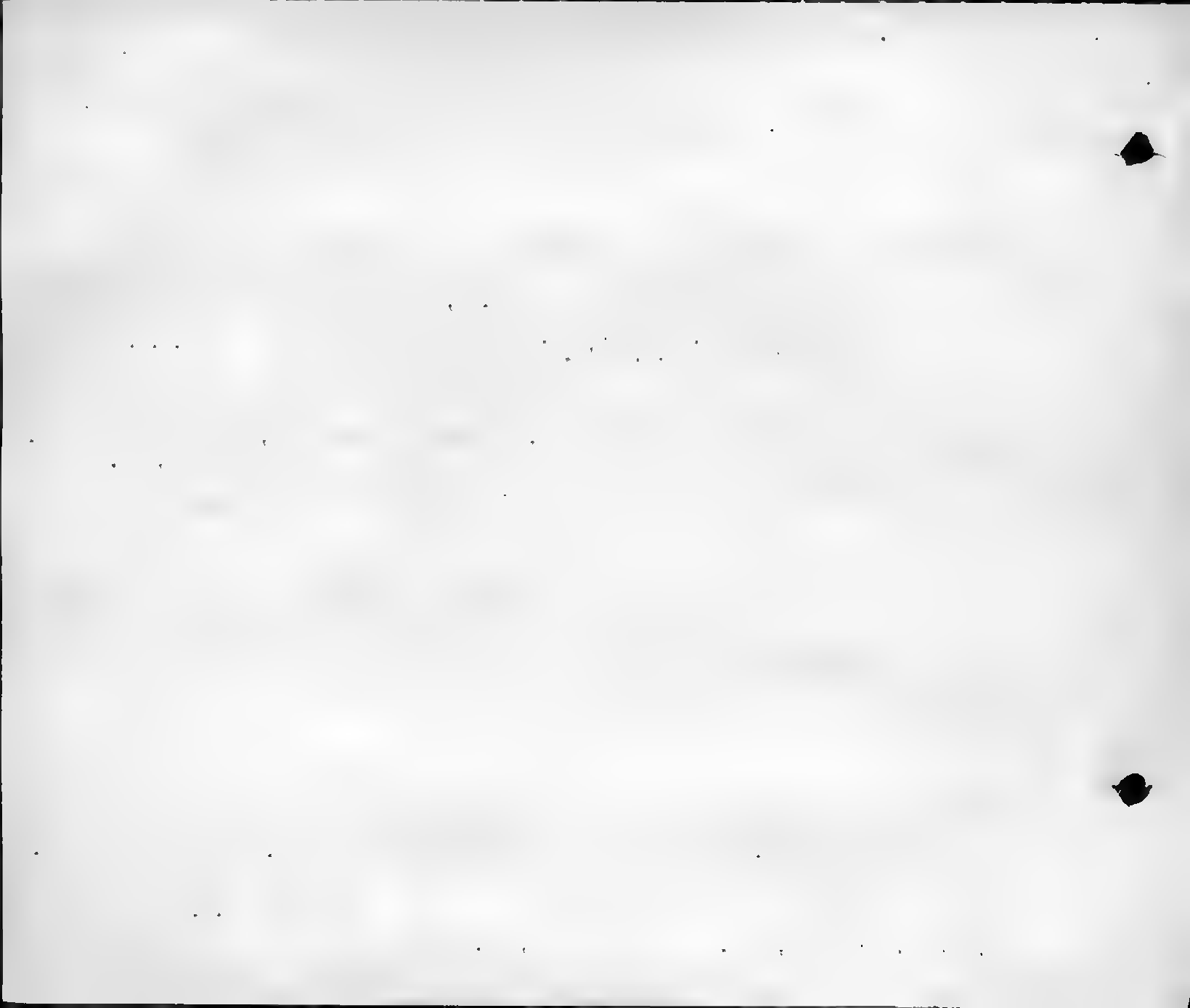
VR A15 (4)
ISM 9/59

4542

4552

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 8712 COLESVILLE ROAD		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle Robert Last OWEN		4. DATE OF DEATH Month APRIL Day 6 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1888
9. AGE (in years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min 0	
11. USUAL OCCUPATION (Give kind of work done, if retired, give last occupation) Supv. Invt. Maint. of Public Works (retired)		12. KIND OF BUSINESS OR INDUSTRY Gen. Service Adm. U.S. Gov't.	
13. BIRTHPLACE (State or foreign country) Ohio		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME William Owen		16. MOTHER'S MAIDEN NAME Emma Mays	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO. none	
19. INFORMANT Mrs. Margaret Ruckert Owen, 8712 Colesville Rd.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis & Left Hemiplegia DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/7 to 4/6 , 19 61 , that (I) (we) last saw the deceased alive on 4/6 , 19 61 and that death occurred at 1015 PM , from the causes and on the date stated above.			
22a. SIGNATURE William D. Aud		22b. DATE SIGNED 4/7/61	
22c. PHYSICIAN'S NAME (Type) WILLIAM D. AUD		22d. ADDRESS 9006 Colesville Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/10/61	
23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		25a. RECEIVED BY REGISTRAR DATE APR 11 '61	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur L. K...	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04533

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 625 W. Lynfield Street		d. STREET ADDRESS 625 W. Lynfield St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HUGH First M. Middle PARKER Last		4. DATE OF DEATH April 27, Month 19 61 Day 19 Year 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1889
9. AGE (In years last birthday) 71 yrs		10. FUND 1 YEAR Months 71 Days 19 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Tenn.	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John W. Parker		14. MOTHER'S MAIDEN NAME Amanda Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Rosa Lee Parker-Item# 2	
17. INFORMANT Rosa Lee Parker-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1201 (c) 1201		INTERVAL BETWEEN ONSET AND DEATH 1201	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 4/29/61	
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.		24a. REC'D BY REGISTRAR DATE MAY 2 '61	
		24b. REGISTRAR'S SIGNATURE Charles E. K...	



TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

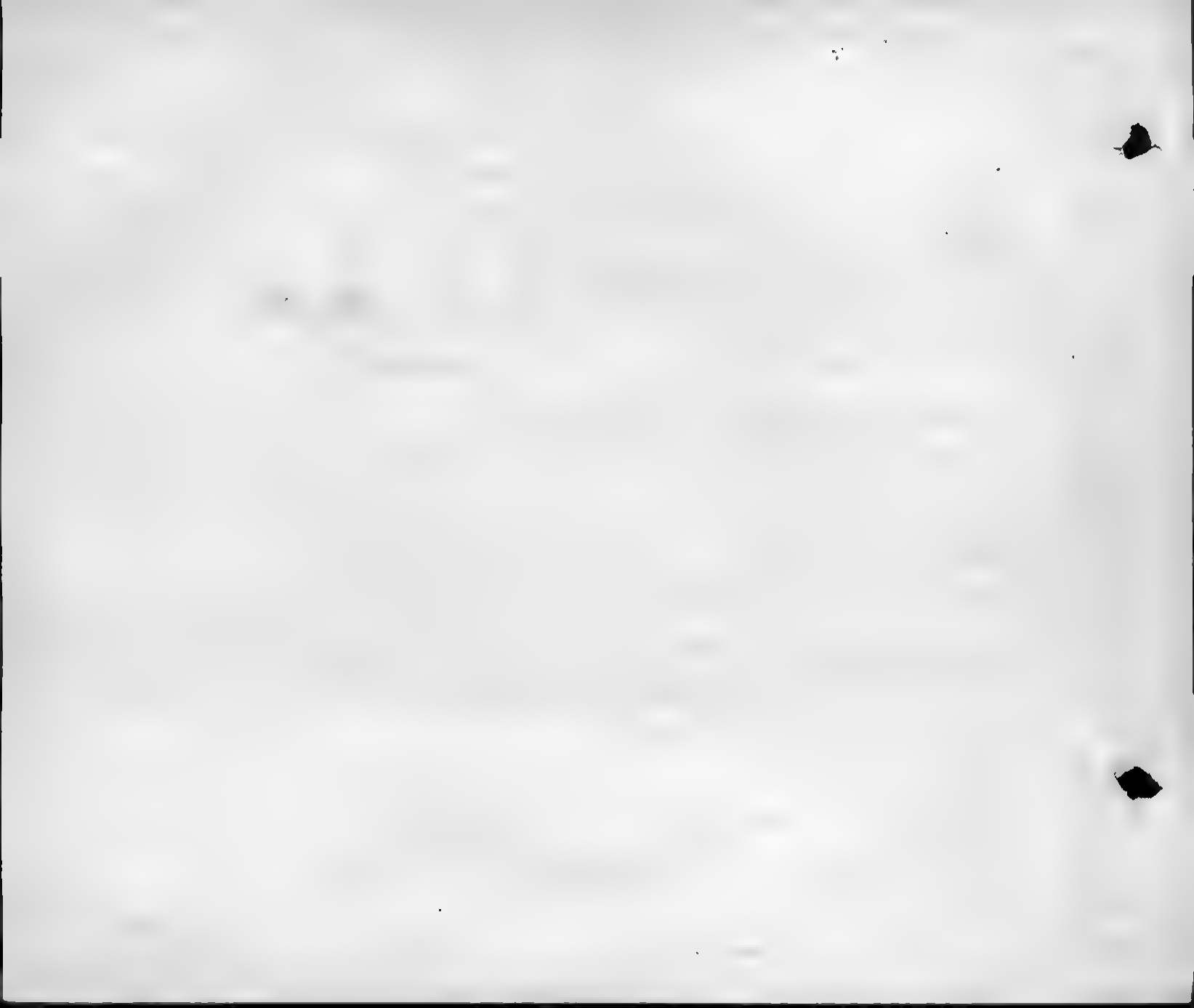
Item 19 Film G285

4/17/61 iwk

04534

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>8 da</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1325 Coral Sea Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Georgia Alma Parrish</u> First Middle Last		4. DATE OF DEATH <u>April 16 1961</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21 1902</u> last birthday Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. FATHER'S NAME <u>Sloter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sloter</u>		14. MOTHER'S MAIDEN NAME <u>Edwards</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Stanley E. Parrish, Gamewabre (son)</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE PULMONARY EMBOLIC INFARCTION 2d.</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Rheumatic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1961</u> to <u>4/16/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/16/61</u> , 19 <u>61</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John A. Jones</u>		22b. DATE SIGNED <u>4/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John A. Jones</u>		22d. ADDRESS <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>BURIAL 4-19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHSEL CHURCH</u>	
23d. LOCATION (City, town or county) <u>LANCASTER CO VA.</u>		(State) <u>—</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lyle</u>		25a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>3004 ST. N. 25</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
DATE <u>APR 19 61</u>		DATE <u>—</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

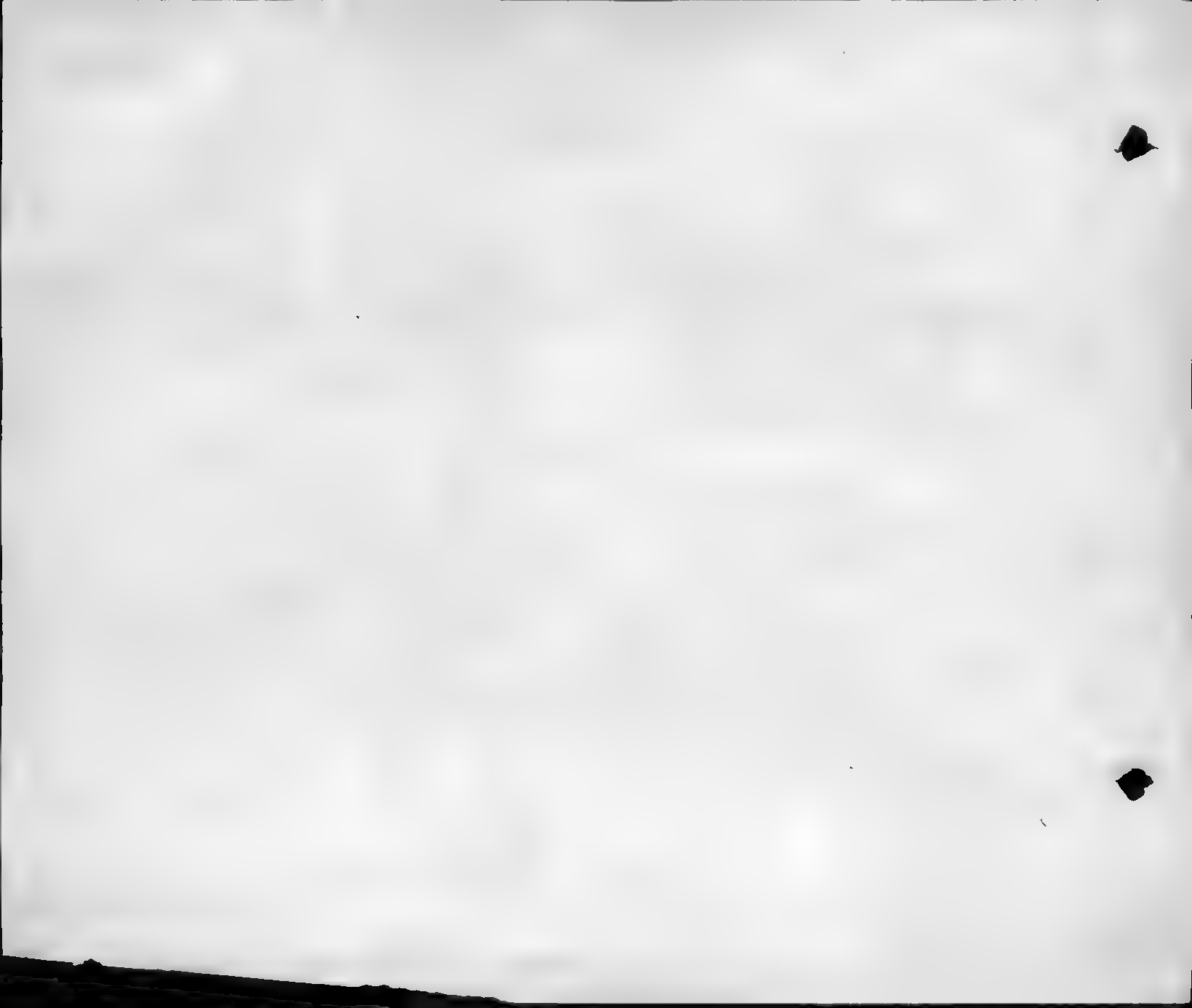
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

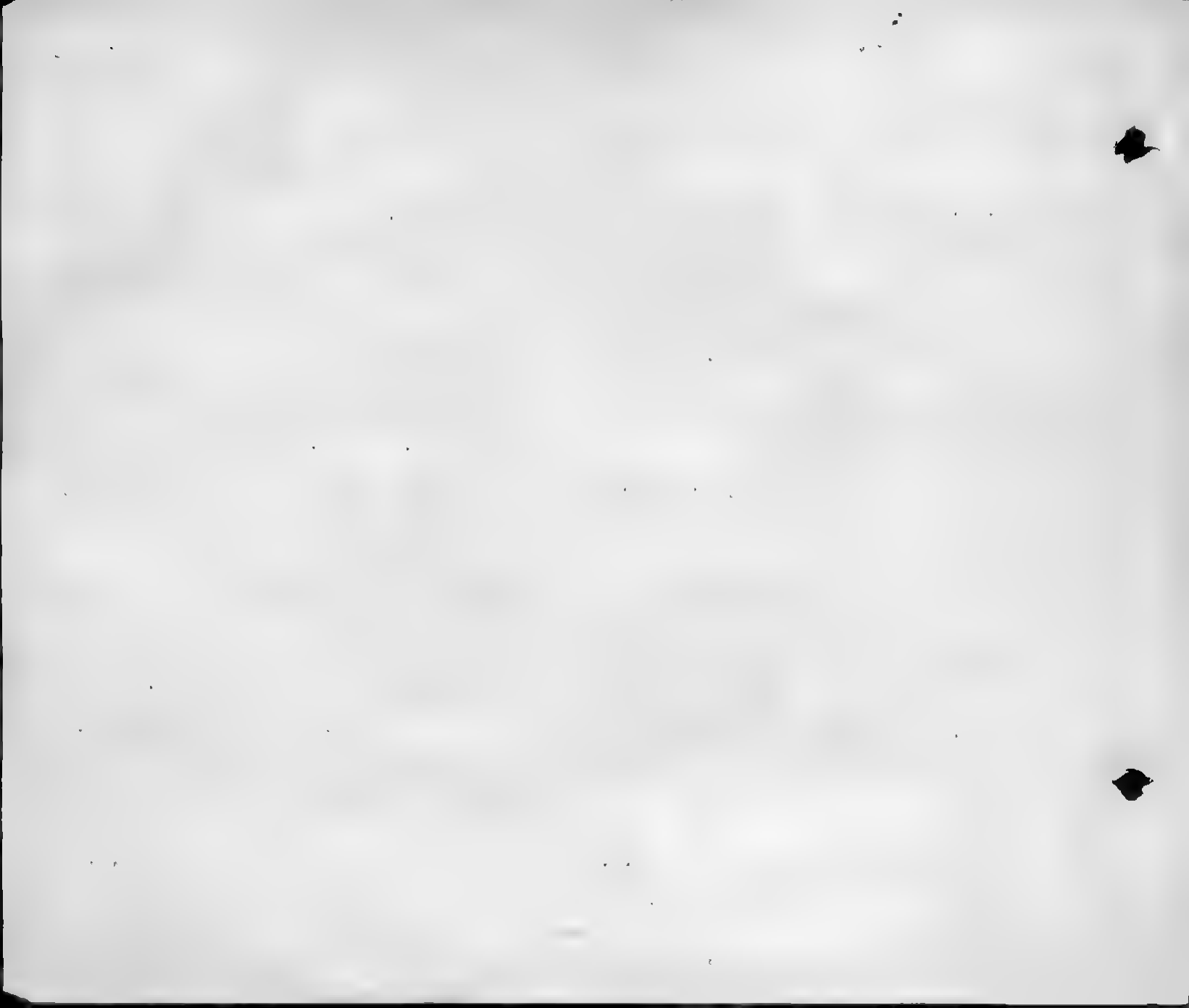
4546

04536

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>+ 1X-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>3325 Dix ST. N.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Guburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ludie Kate Perry</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10 1926</u>	
9. AGE in years IF UNDER 1 YEAR last birthday Months Days <u>35</u> yrs		10. AGE in years IF UNDER 24 HRS. last birthday Hours Mins. <u>35</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jack Calloway</u>		14. MOTHER'S MAIDEN NAME <u>Freeman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-32-6605</u>	
17. INFORMANT <u>James E. Perry, same as above.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a., (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breast & metastases to bones, liver and cervical nodes.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>17C X</u> DUE TO (c) <u>17C X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>July</u> 19 <u>60</u> to <u>April 2</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March 25</u> , 19 <u>61</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stanley J. Talper M.D.</u>		22b. DATE SIGNED <u>April 2 1961</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Thompson</u>		25a. REC'D BY REGISTRAR <u>Bellevue</u>	
25b. REGISTRAR'S SIGNATURE <u>Bellevue</u>		DATE <u>APR 7 '61</u>	



Arthur L. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4548

04588

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 84 Magazine Street			
3. NAME OF DECEASED (Type or print) First Walter Middle Henry Last Paul Peterson				4. DATE OF DEATH Month April Day 21 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1919		9. AGE (In years last birthday) 42 yes	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter P. Peterson				14. MOTHER'S MAIDEN NAME Janie Hodgkiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 138-12-7639		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mitral insufficiency with congestion of the lungs DUE TO insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Rheumatic heart disease, Mitral stenosis and mitral Years DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 9 19 61 to April 21 19 61 that (I) (we) last saw the deceased alive on April 21 19 61 , and that death occurred at 1:55 PM from the causes and on the date stated above							
22a. SIGNATURE Roland Folse, MD				22b. DATE SIGNED 4/22/61			
22c. PHYSICIAN'S NAME (Type) J. ROLAND FOLSE, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-23-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Laurel Grove Mem. Park		23d. LOCATION (City, town, or county) (State) Paterson, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE APR 25 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hearn			

MEDICAL CERTIFICATION

2

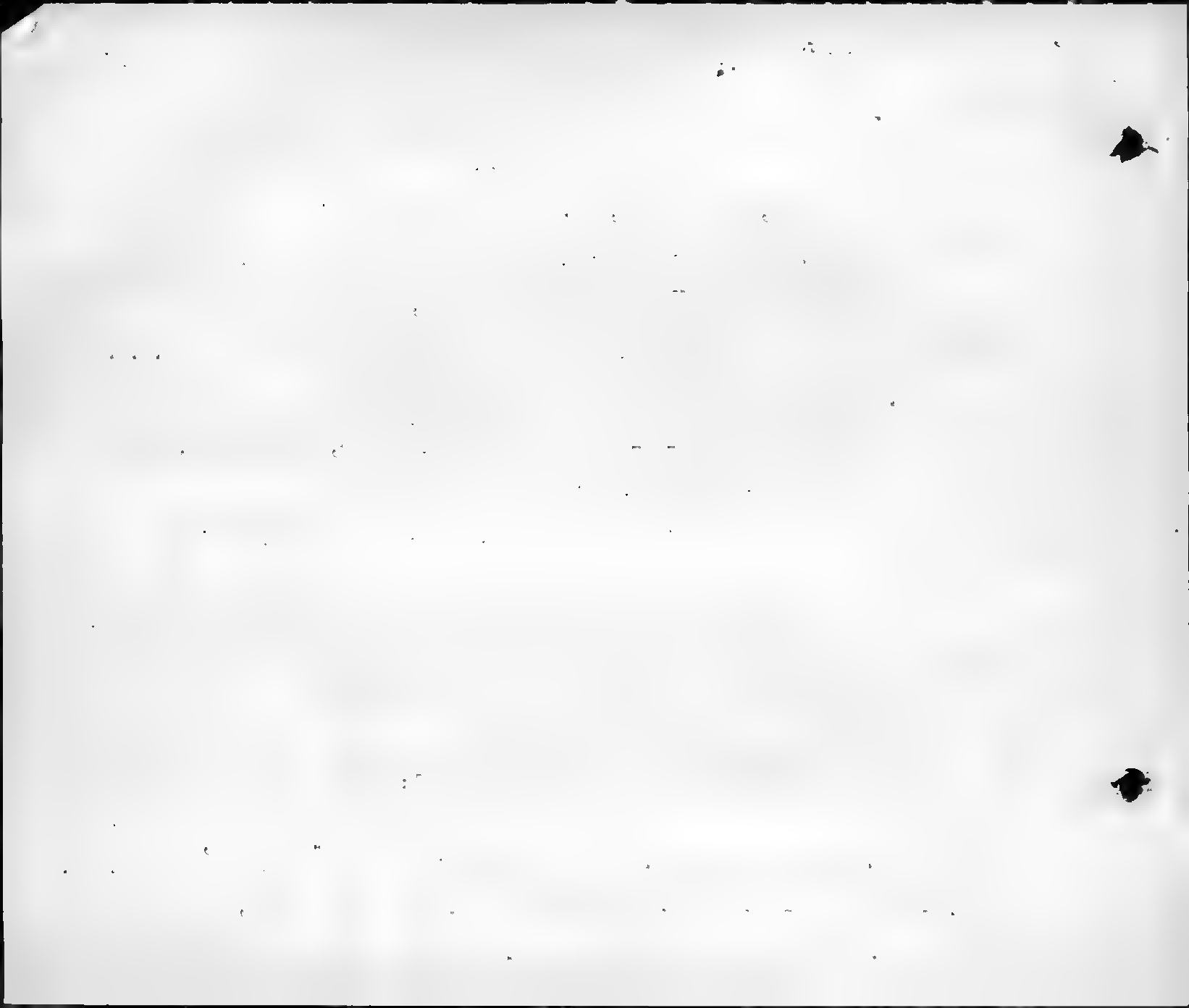
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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



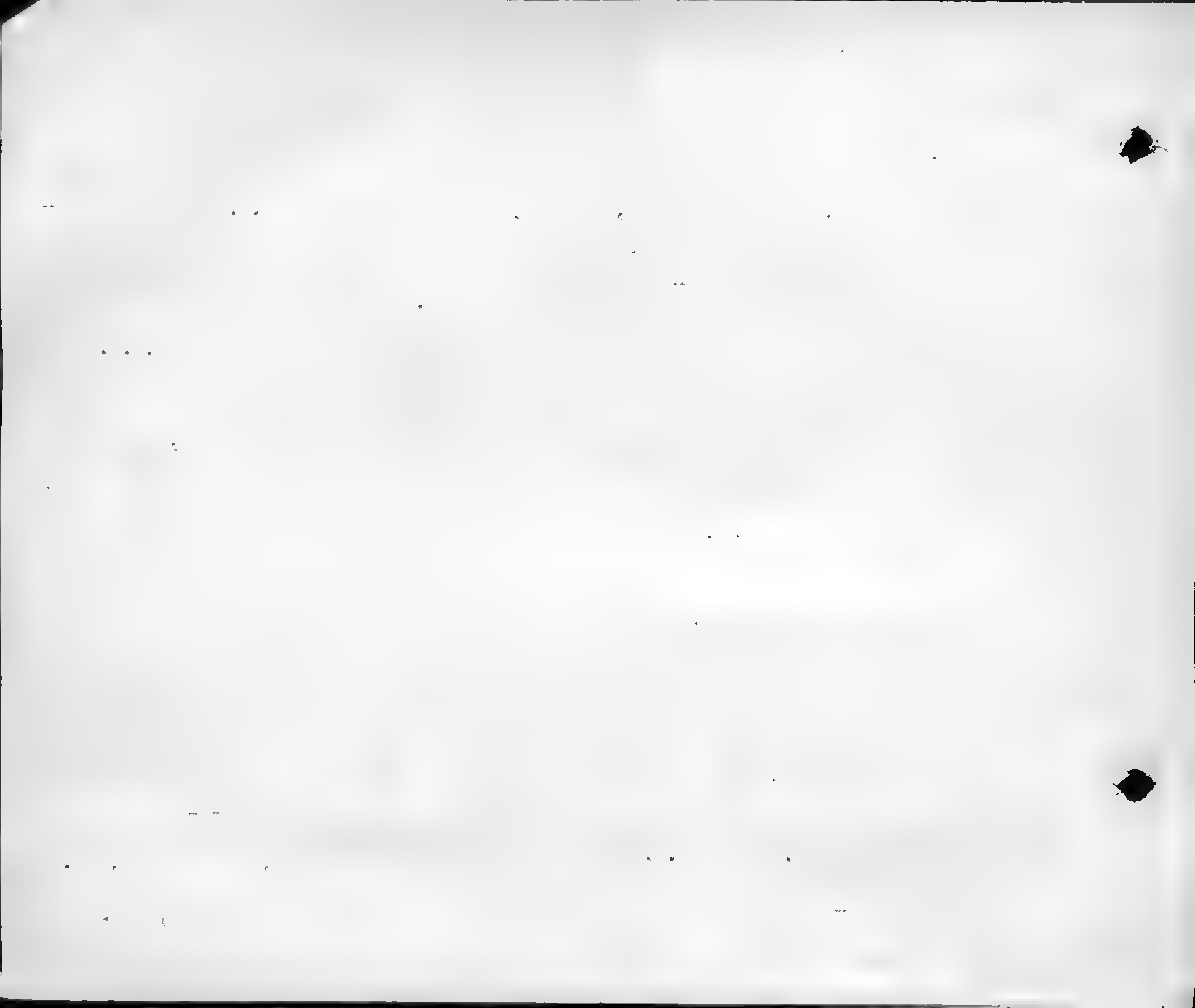
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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4549
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04533

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 46 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3819 Beecher Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Ruby Middle Arlena Last Pippel		4. DATE OF DEATH Month April Day 8 Year 19 61	
5. SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 8, 1920
9. AGE (In years last birthday) 40 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None
11 BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Guy Strickland		14. MOTHER'S MAIDEN NAME Lora Wheelus	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO Unascertainable	
17 INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Septecemia 204 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myelogenous Leukemia DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Congestive heart failure			INTERVAL BETWEEN ONSET AND DEATH 24 Hours 2 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 21, 19 61 to April 8, 19 61 , that (I) (we) last saw the deceased alive on April 8, 19 61 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward E. Morse		22b. DATE SIGNED 4-8-61	
22c. PHYSICIAN'S NAME (Type) Edwrd E. Morse M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-12-1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Gencarelli		25a. REC'D BY REGISTRAR APR 12 '61	
ADDRESS 1756 Pacific Ave		25b. REGISTRAR'S SIGNATURE Caroline L. Hanna	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

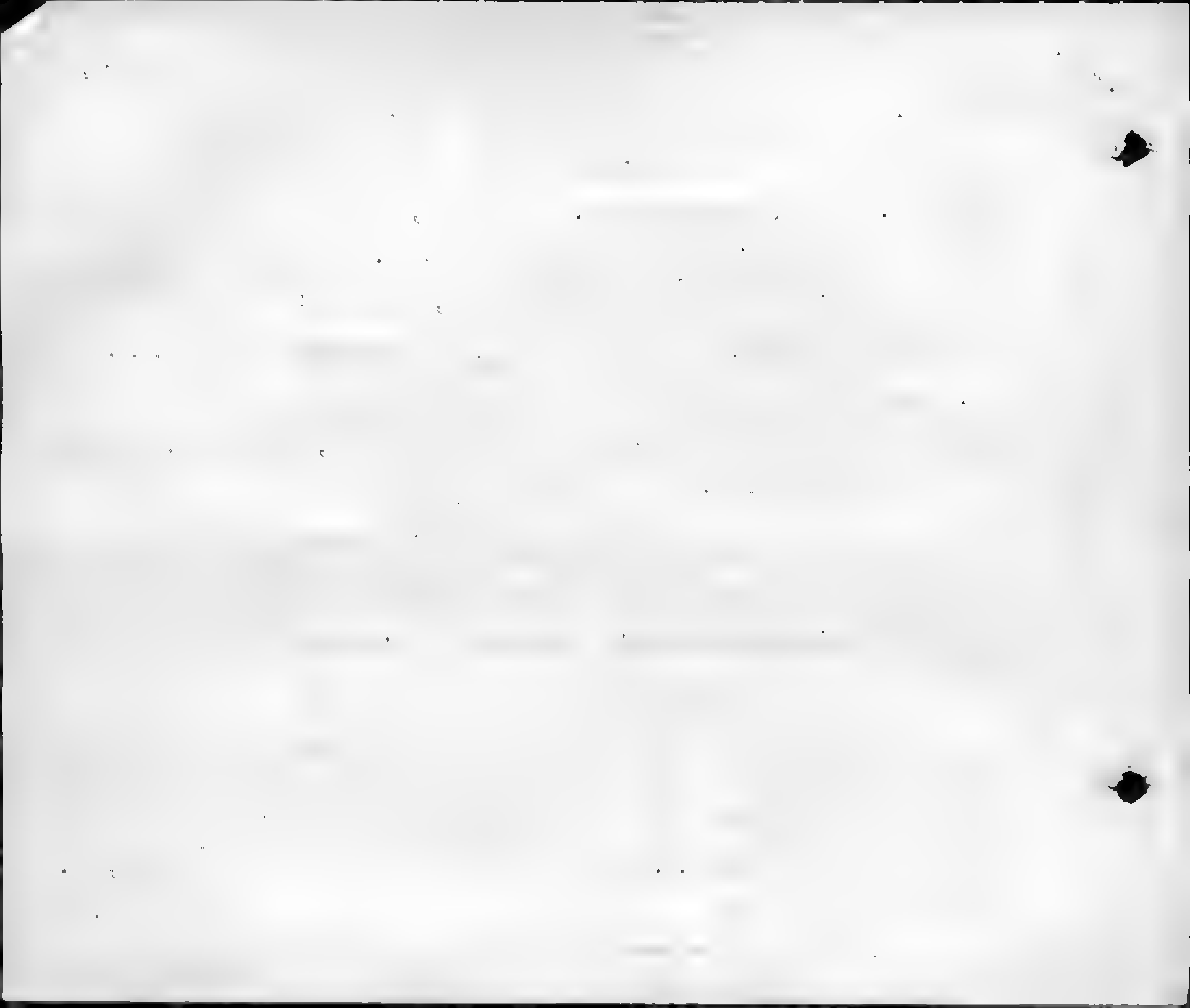
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04540

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 98 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Loris c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route # 4, Box 88 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elbert Delano Porter, Sr.		4. DATE OF DEATH Month Day Year April 23 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1938
9. AGE (In years last birthday) 22		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agricultural Statistician		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J.R. Porter		14. MOTHER'S MAIDEN NAME Eunice Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia producing shock DUE TO spread Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Chondrosarcoma of right hip with extensive local DUE TO 17 months (c) Metastatic chondrosarcoma of lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) of right lung Acute & chronic pyelonephritis; partial obstruction sigmoid colon; abscess			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20f. (City or town) (County) (State) January 15, 1961, to April 23, 1961, that (X) (we) last saw the deceased alive on April 23, 1961, and that death occurred at 7:25 AM from the causes and on the date stated above	
21. I certify that (this hospital) attended the deceased from January 15, 1961, to April 23, 1961, that (X) (we) last saw the deceased alive on April 23, 1961, and that death occurred at 7:25 AM from the causes and on the date stated above		22a. SIGNATURE Martin Nydick M.D. 22b. DATE 4/23/61	
22c. PHYSICIAN'S NAME (Type) MARTIN NYDICK, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 4/24/61		23b. DATE THEREOF 4/24/61	
23c. NAME OF CEMETERY OR CREMATORY Bethesda, Maryland		23d. LOCATION (City, town, or county) (State) S. Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR APR 25 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kinard	



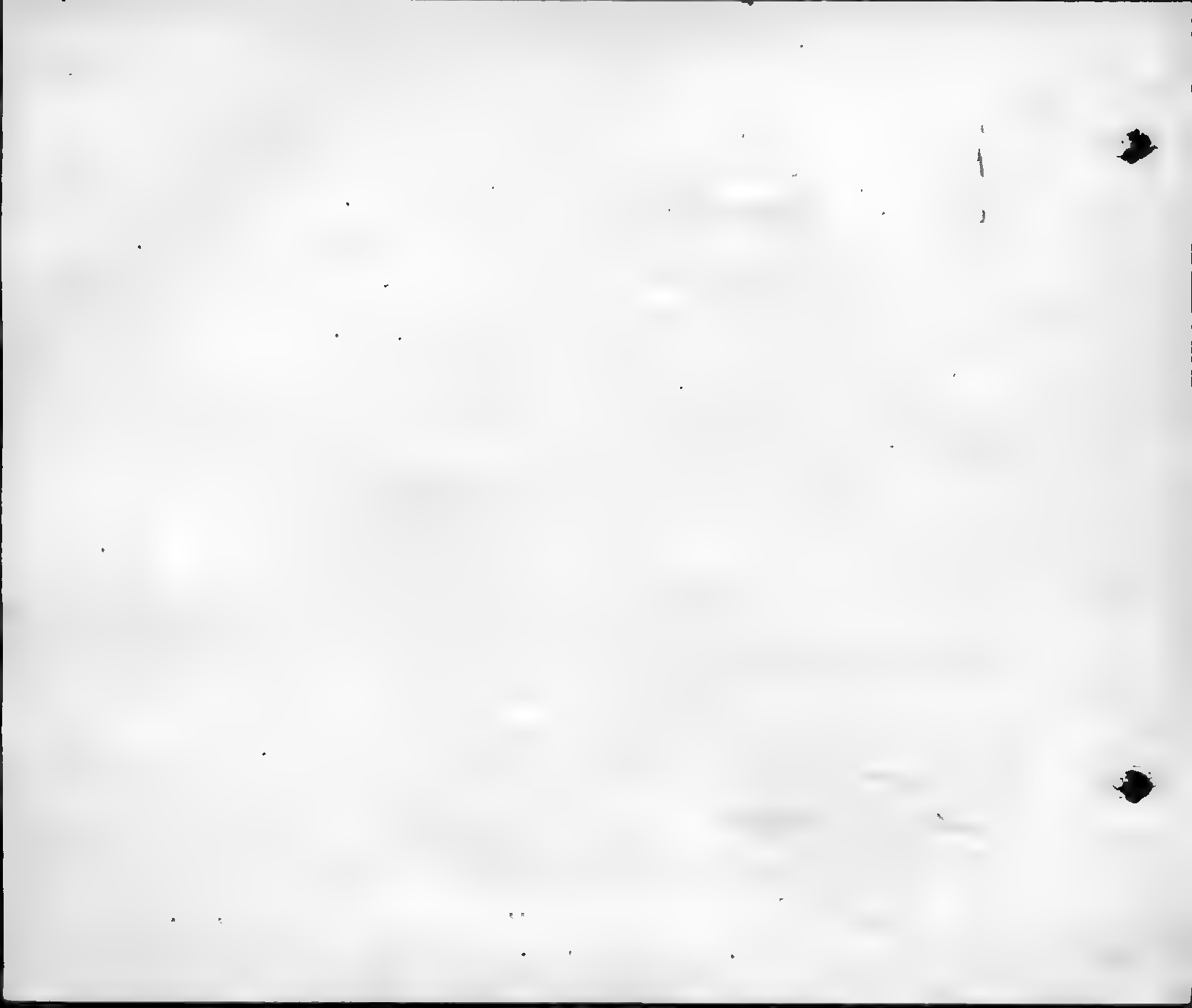
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4
15M 9/59

4551
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04541

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>Kensington</u> d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>16701 Shaftsbury Street</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>16701 Shaftsbury St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elisha</u> First <u>Pratt</u> Last 4. DATE OF DEATH <u>4</u> Month <u>7</u> Day <u>1961</u> Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>January 1, 1912</u> 9. AGE (In years last birthday) <u>59</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitation</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Board Education</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CIEM PRATT</u> 14. MOTHER'S MAIDEN NAME <u>Florence THORN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (c) <u>Arteriosclerotic Heart Disease</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> to <u>April 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1961</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above 22a. SIGNATURE <u>George Sharpe</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u> 22d. ADDRESS <u>10511 Summit Ave Kensington, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/11/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u> 23d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert K. Snowden</u> ADDRESS <u>Rockville, Md.</u> 25a. REC'D BY REGISTRAR DATE <u>APR 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	



1
4552

4552

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 8 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi	
		d. STREET ADDRESS 9412 Adelphi Road, Apt. #2	
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Dean Pringle		4. DATE OF DEATH Month Day Year April 6, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 September 1930
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leon LeBlanc		14. MOTHER'S MAIDEN NAME Elizabeth Nix	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 463-36-5159	
17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland			

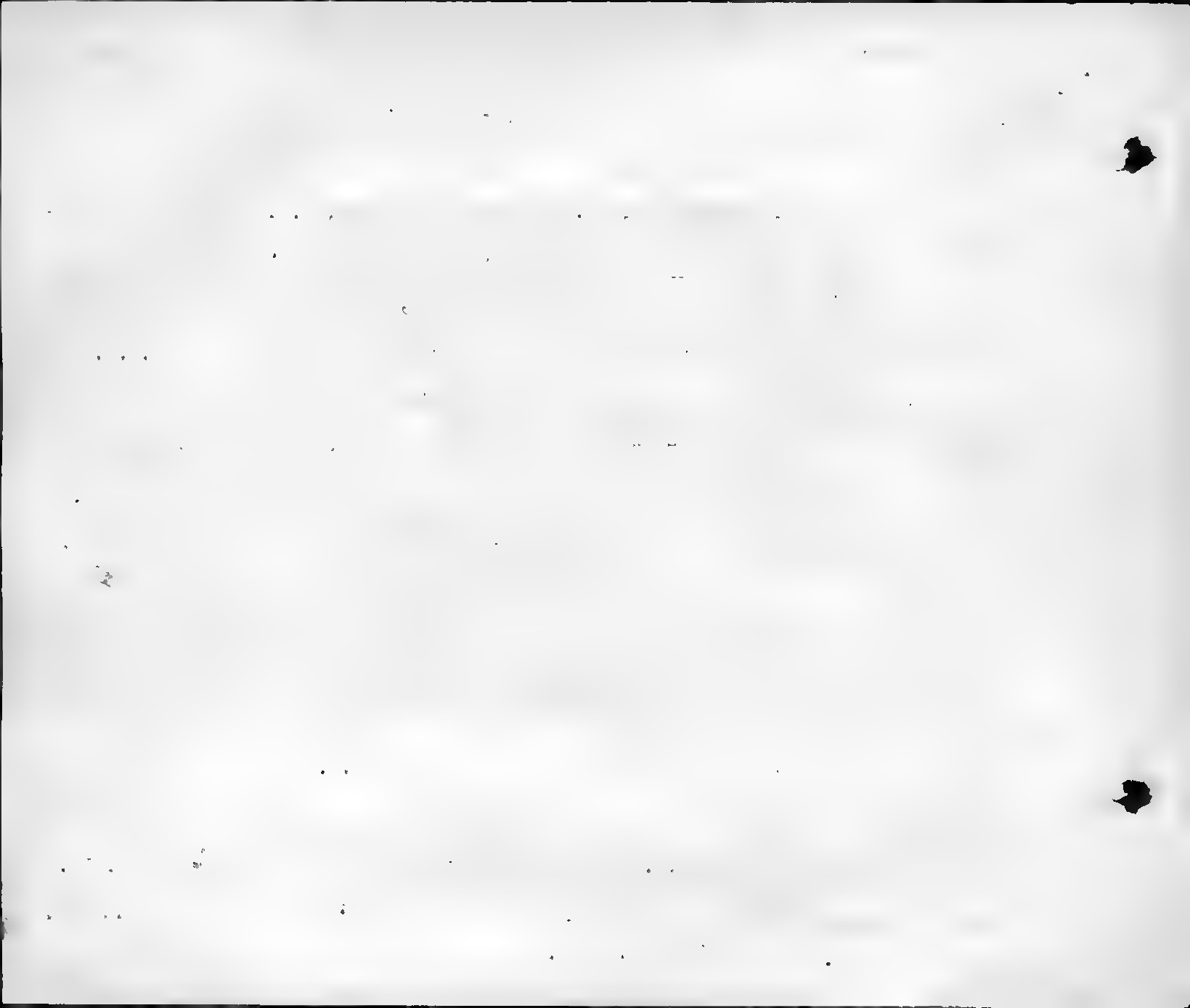
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure		7 days	
DUE TO (b) Cardiac hemosiderosis		2-3 years	
DUE TO (c) Aplastic anemia		7 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it) (this hospital) attended the deceased from March 29, 1961 to April 6, 1961 , that (it) (we) last saw the deceased alive on April 6, 1961 , and that death occurred at 1:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE Leon E. Rosenberg M.D.		22b. DATE SIGNED 4/6/61	
22c. PHYSICIAN'S NAME (Type) Leon E. Rosenberg, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	

23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	23b. DATE THEREOF 4-7-61	23c. NAME OF CEMETERY OR CREMATORY SPRINGTOWN	23d. LOCATION (City, town, or county) (State) SPRINGTOWN MD
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Henders CC 1400 CAMPBELL ST		25a. REC'D BY REGISTRAR APR 10 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





Page 4

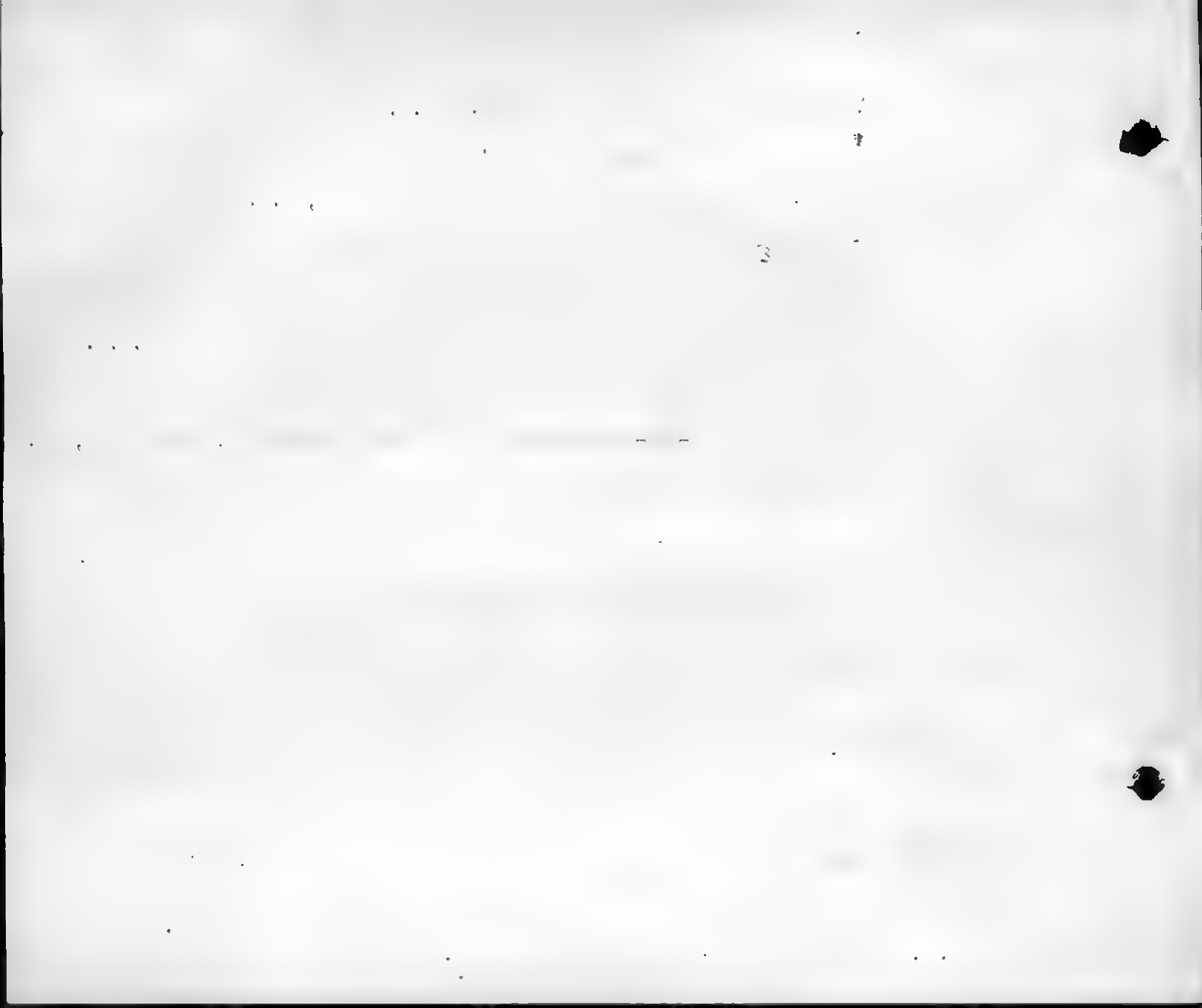
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4554

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04544

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 24 days		d. STREET ADDRESS 3880 Porter Street, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Terese Middle E. Last Ramisch		4. DATE OF DEATH Month April Day 3 Year 1961	
5 SEX F	6 COLOR OR RACE White	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1881
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kisler		14. MOTHER'S MAIDEN NAME Julienne Bruckner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 577-20-4462	
17 INFORMANT Akensington Gardens Sanitarium, Kensington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis with (c) Hypertensive Coronary Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		INTERVAL BETWEEN ONSET AND DEATH 20 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 1955 to April 2, 1961 , that (I) (we) last saw the deceased alive on April 2, 1961 , and that death occurred at 5:40 A.M. from the causes and on the date stated above			
22a. SIGNATURE F. P. Andrews		22b. DATE SIGNED 4-3-61	
22c. PHYSICIAN'S NAME (Type) F. P. ANDREWS		22d. ADDRESS 4201 FESSENDEN ST. N.W. WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/1961	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24 FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company-2901 14th St. N.W.		25a. REC'D BY REGISTRAR APR 4 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Hines		25c. ADDRESS Washington 9, D.C.	



4555

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8704-Brickyard Rd.</u>		d. STREET ADDRESS <u>8704-Brickyard Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET R RANDALL</u>		4. DATE OF DEATH <u>APRIL 7 1961</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter Little</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hoody</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Best M. Randall</u>		Address <u>8704-Brickyard Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>20 years +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 10 1942</u> to <u>April 7 1961</u> , that I last saw the deceased alive on <u>April 5 1961</u> , and that death occurred at <u>4:15 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3409 Wisconsin Ave N.W.</u> DATE SIGNED <u>4-7-61</u>			
ACTUAL SIGNATURE <u>John H Hazard</u> M.D.		PHYSICIAN'S NAME (Type) <u>John H Hazard Washington D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-10-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hall Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>3072 M. St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 11 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4556

04546

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN lb <u>3 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens SAN.</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u> d. STREET ADDRESS <u>3503 Woodbine ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Catherine G. Reith</u>		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1961</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>7/8/1870</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>			
13. FATHER'S NAME <u>William Reith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rose Caspar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Sanitarium Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AORTIC STENOSIS</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital), attended the deceased from... <u>8</u>, 195 <u>7</u> to <u>APRIL 20</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>4-20</u> 19 <u>61</u> , and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stanley M. Silverberg</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-20-61</u>		22c. PHYSICIAN'S NAME <u>STANLEY M. SILVERBERG, M.D.</u> 22d. ADDRESS <u>1834 CONN. AVE. N.W. WASH, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		23d. LOCATION (City, town or county) <u>Washington D.C.</u> (State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Sears Sons Co</u>		ADDRESS <u>3605-14 St NW</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 24 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4553

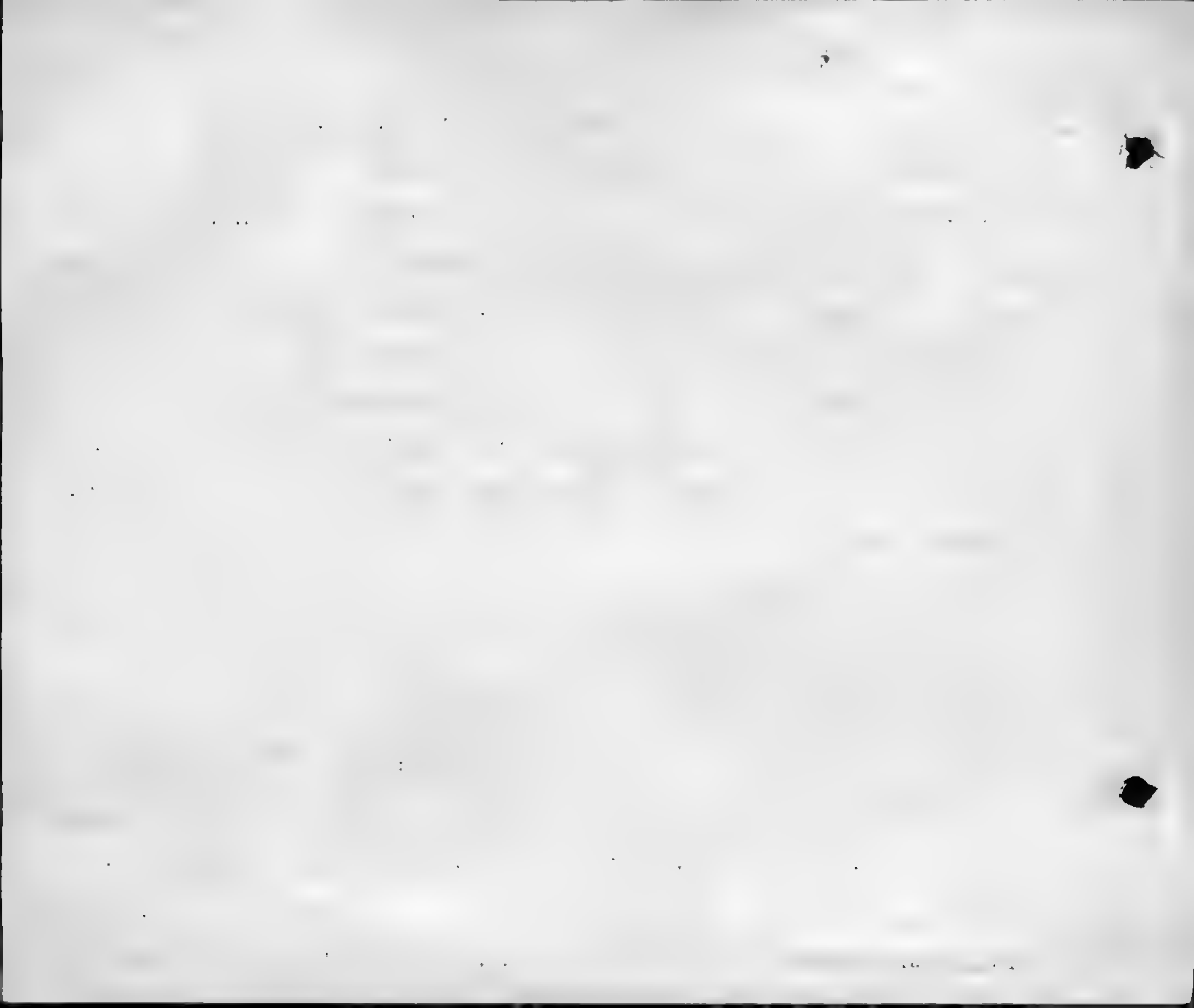
04547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 11 days NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 804 Hamilton Street, N.E. d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Julian Hawthorne RICHARDSON		4. DATE OF DEATH April 29 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		8b. KIND OF BUSINESS OR INDUSTRY Virginia		9. AGE (In years last birthday) 55 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (County & State or foreign country) USA			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nelson RICHARDSON		14. MOTHER'S M&A DEN NAME Susy (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 577-07-3157		17. INFORMANT Mrs. Emma Richardson, same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, squamous cell, larynx DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County)		20g. (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 18, 1961 to April 29, 1961 that (we) last saw the deceased alive on April 29, 1961, and that death occurred at 9:50AM, from the causes and on the date stated above.							
22a. SIGNATURE T. E. TAYLOR, LT, MC, USN		22b. DATE SIGNED 4-29-61		22c. PHYSICIAN'S NAME (Type) T. E. TAYLOR, LT, MC, USN			
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia		25a. REC'D BY REGISTRAR			
24. FUNERAL DIRECTOR'S SIGNATURE Hall Bros. Undertakers, 621 Florida Ave., N.W.		25b. REGISTRAR'S SIGNATURE Arthur L. Finner		25c. DATE MAY 3 '61			



Page 4
1
(M)
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
(I)
1

4558
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04548

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Washington, DC</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>15106 New Port Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>F.</u> Middle <u>Riecks</u> Last		4. DATE OF DEATH Month <u>Apr.</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR: Months <u>85</u> Days <u>85</u> Hours <u>85</u> Min <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl Frederick Riecks</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Benjamin</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Charles B. Riecks</u> son		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u>		DUE TO (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1950</u> to <u>April 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Hazard</u>		22b. DATE SIGNED <u>4-4-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hazard, M.D.</u>		22d. ADDRESS <u>3409 Wisconsin Ave. NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glennwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>300-4 SINE DC</u>	
25b. REGISTRAR'S SIGNATURE <u>APR 10 '61</u>		25c. REGISTRAR'S SIGNATURE <u>Charles B. Riecks</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 m. retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04544

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u></p> <p>c. LENGTH OF STAY IN 1b <u>3 1/2 days</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u></p>												<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>D.C.</u> b. COUNTY <u>Washington (16)</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington (16)</u></p> <p>d. STREET ADDRESS <u>3911 Langley Court NW.</u></p> <p>6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Lindwood</u> Last <u>Riley</u></p> <p>4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1961</u></p>												<p>5. SEX <u>Female</u></p> <p>6. COLOR OR RACE <u>White</u></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>February 7, 1887</u> 74 yrs.</p> <p>9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u> IF UNDER 24 HRS. Hours <u>74</u> Min. <u>74</u></p>											
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>—</u></p> <p>11. BIRTHPLACE (Country & State, or foreign country) <u>Virginia</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>												<p>13. FATHER'S NAME <u>John E Beale</u></p> <p>14. MOTHER'S M maiden NAME <u>Nancy Lunsford</u></p>											
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes give year or dates of service)) <u>—</u></p> <p>16. SOCIAL SECURITY NO. <u>—</u></p> <p>17. INFORMANT <u>Robert Milton Riley (son)</u> Address <u>78 Borden Rock Rd, Levittown, Pa.</u></p>												<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u></p> <p>Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension Cardio Vascular Disease</u></p> <p>(a), stating the underlying cause last. (c) <u>—</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Myelitis, Cholelithiasis</u></p> <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>											
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u></p> <p>20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u></p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u></p> <p>20f. (City or town) (County) (State) <u>—</u></p>												<p>21. I certify that (I) (this hospital) attended the deceased from <u>June 1950</u> to <u>April 9, 1961</u>, that (I) (we) last saw the deceased alive on <u>4-8-1961</u> and that death occurred <u>4-9-1961</u> from the causes and on the date stated above.</p> <p>22a. SIGNATURE <u>P.P. Andrews</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p> <p>22b. DATE SIGNED <u>4-9-61</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS</u></p> <p>22d. ADDRESS <u>WASHINGTON D.C.</u></p>											
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>23b. DATE THEREOF <u>4/12/61</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Res. Wash. Cem</u></p> <p>23d. LOCATION (City, town or county) (State) <u>Riggs Rd. MD</u></p>												<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Samuel</u> ADDRESS <u>5109 Wisconsin Ave NW, Wash. D.C.</u></p> <p>25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u></p> <p>DATE <u>APR 12 '61</u> <u>William S. Kraus</u></p>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

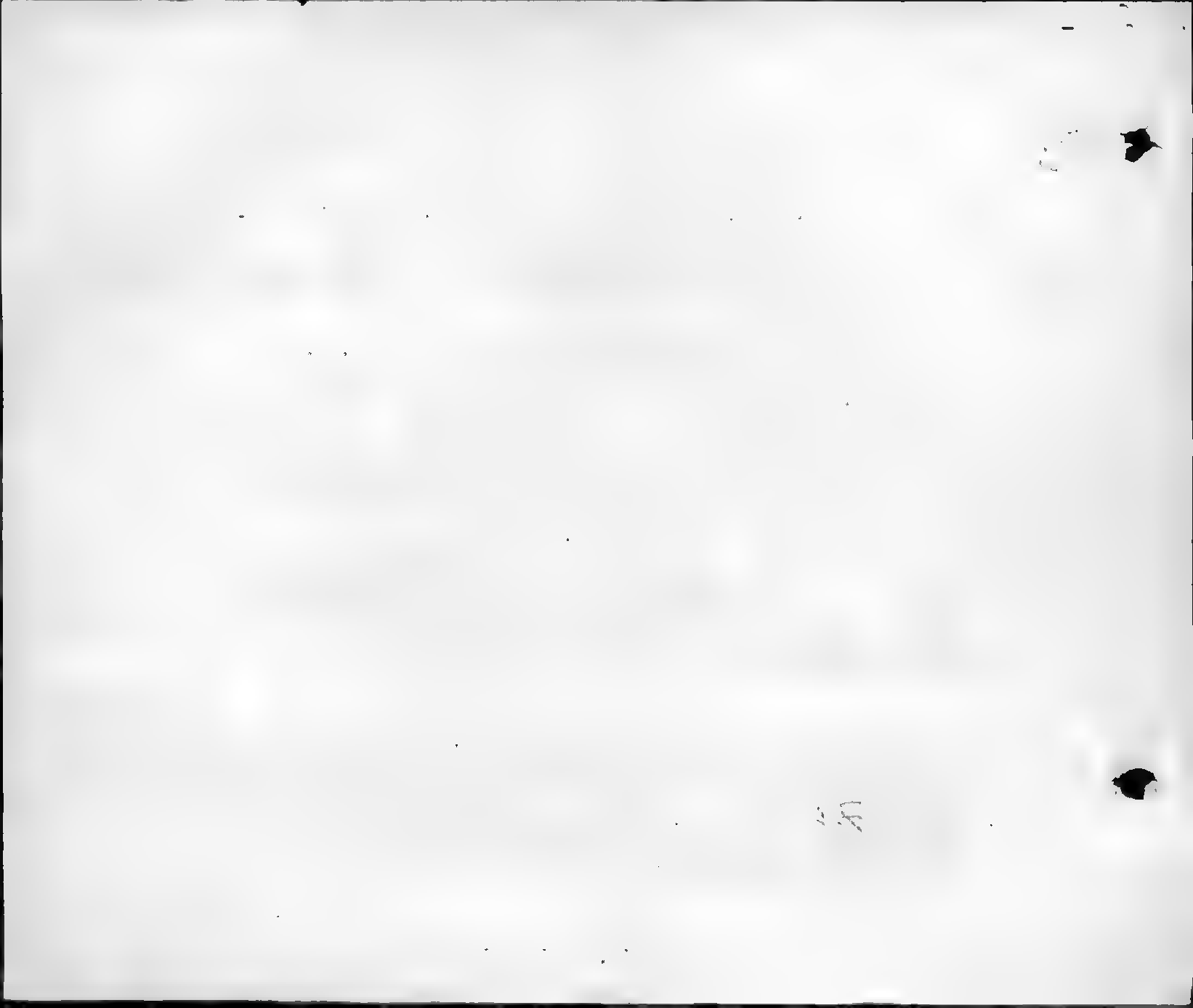
VR A15 (4)
15M 9/59

4560

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04550

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ROCKVILLE d. STREET ADDRESS 1 221 S. WASHINGTON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FORSYTH Last ROBERTSON		4. DATE OF DEATH Month APRIL Day 27 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/11
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months 4 Days 27 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FINANCE OFFICER		10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D. C.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM V. ROBERTSON		14. MOTHER'S MAIDEN NAME JOSEPHINE FORSYTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND	
18. CAUSE OF DEATH {Enter on only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated peptic ulcer DUE TO duodenum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Acute peritonitis DUE TO Acute peritonitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 3:15 A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County, (State)	
21. I certify that (I) (this hospital) attended the deceased from April 23, 1961 , to April 27, 1961 , that (I) (we) lost saw the deceased alive on April 27, 1961 , and that death occurred at 3:15 A M, from the causes and on the date stated above.			
22a. SIGNATURE Arthur F. Woodward		22b. DATE SIGNED APRIL 27 1961	
22c. PHYSICIAN'S NAME (Type) A. F. WOODWARD, M. D.		22d. ADDRESS ROCKVILLE, MARYLAND	
23a. BURIAL CREMATION burial (Specify)		23b. DATE THEREOF 4/30/61	
23c. NAME OF CEMETERY OR CREMATORY Rockville		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 E. Montg. Ave., Rockville, Md.		25a. REC'D BY REGISTRAR DATE MAY 2 '61	
25b. REGISTRAR'S SIGNATURE Clifton L. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

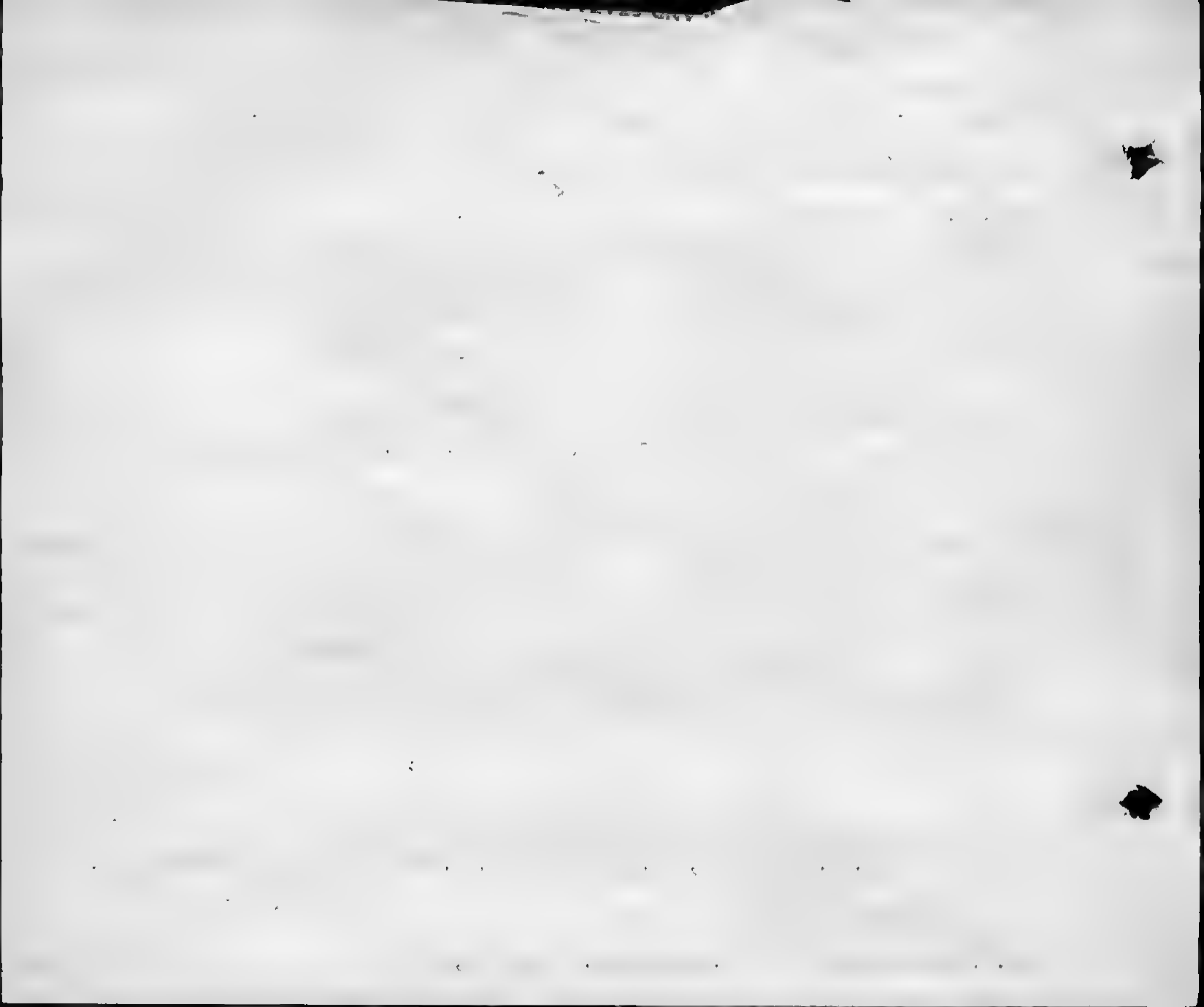
4561

04551

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate has been retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if not in town: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>RFD #5</u>			
3. NAME OF DECEASED (Type or print) <u>Anna Kane ROSS</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-6-92</u>	
9. AGE (in years last birthday) <u>68</u> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State or foreign country) <u>Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John KANE</u>			
14. MOTHER'S MAIDEN NAME <u>Mora DOWNS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>033-09-4509 (D)</u>				17. INFORMANT <u>Mrs. Agnes R. Castagliola, same as #2 above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>April 17, 1961</u> to <u>April 20, 1961</u> , that (s) (we) last saw the deceased alive on <u>April 20, 1961</u> , and that death occurred at <u>8:10AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED <u>4-20-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. M. YOUNG, LT, MC, USN</u>				22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment</u>		23b. DATE THEREOF <u>4-22-61</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <u>Lawrence, Massachusetts</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son</u>				25a. REC'D BY REGISTRAR <u>APR 24 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>				25c. ADDRESS <u>Md.</u>			



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VR A15 (4)
15M 9/59

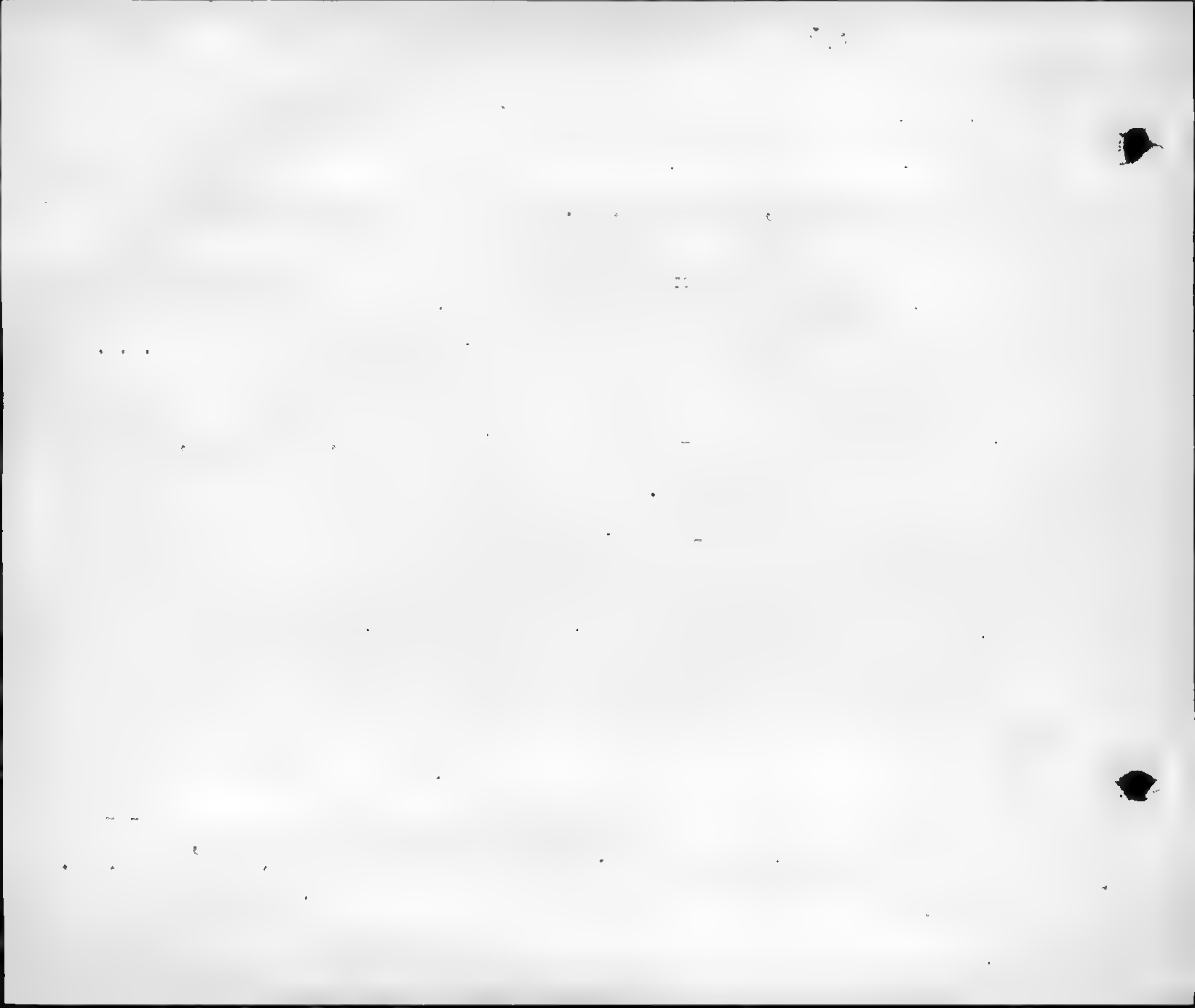
4562

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04552

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Ohio b. COUNTY Hubbard			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2108 Hubbard Youngstown Road			
3. NAME OF DECEASED (Type or print) First George Middle Samuel Last Salomon				4. DATE OF DEATH Month April Day 6 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1908	
9. AGE (In years (last birthday)) 53 yrs		10. IF UNDER 1 YEAR Months 53 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Auto parts		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME George Salomon				14. MOTHER'S MAIDEN NAME Lillian Hebrank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 172-09-1439		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) Cardiac Arrest 722.0 DUE TO (b) Post-operative Bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Surgical Replacement of Aortic Valve							INTERVAL BETWEEN ONSET AND DEATH 24 Hours 24 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Aortic Valve Insufficiency secondary to Rheumatoid Arthritis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19, 1961 to April 6, 1961 , that (I) (we) last saw the deceased alive on April 6, 1961 , and that death occurred 7:50 P.M. from the causes and on the date stated above							
22a. SIGNATURE James L. Talbert				22b. DATE SIGNED 4-7-61			
22c. PHYSICIAN'S NAME (Type) JAMES L. TALBERT, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/3/61		23c. NAME OF CEMETERY OR CREMATORY WEST VUE		23d. LOCATION (City, town, or county) (State) MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hume				25a. REC'D BY REGISTRAR DATE APR 10 1961		25b. REGISTRAR'S SIGNATURE Charles E. Hume	

Handwritten signature



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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4563

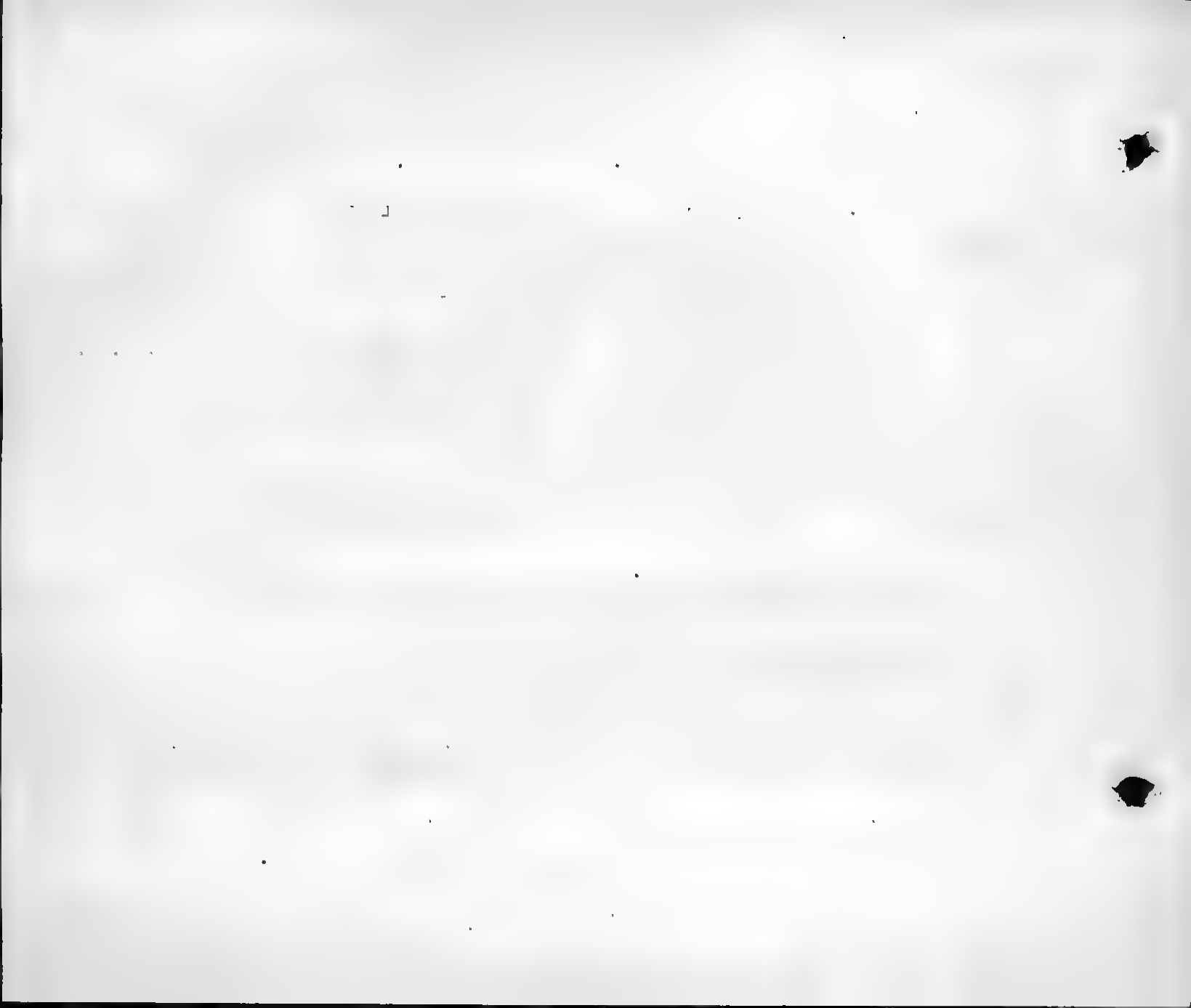
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04553

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			
c. LENGTH OF STAY IN 1b 1 MONTH				d. STREET ADDRESS 902 NEAR DRIVE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM GEORGE SAMPSON				4. DATE OF DEATH Month Day Year APRIL 25 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1875	9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME LEROY SAMPSON				
14. MOTHER'S MAIDEN NAME REBECCA WEBB			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None				
16. SOCIAL SECURITY NO None			17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last THROMBOSIS AT CORONARY ARTERY (b) BILATERAL BRONCHOPNEUMONIA BILATERAL (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day Year Hour o m p m 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 3-6 1961 to April 25 1961 , that (I) (none) last saw the deceased alive on April 2-5 1961 , and that death occurred on April 25 1961 , from the causes and on the date stated above.							
22a. SIGNATURE Arthur F. Woodward M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/26/61	
22c. PHYSICIAN'S NAME (Type) DR. A. F. WOODWARD				22d. ADDRESS ROCKVILLE, MARYLAND			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) 4-29-61 Rose Land Cem		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY ROCKVILLE, VA		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home ADDRESS 300-4 ST. N. E.				25a. REC'D BY REG. STRAR MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4564

04554

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN <u>Bethesda</u> c. LENGTH OF STAY IN <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3416 Rittenhouse St. N.W.</u> d. STREET ADDRESS <u>3416 Rittenhouse St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy S. Schermerhain</u>		4. DATE OF DEATH <u>April 15 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/5/94</u>	9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months <u>15</u> Days <u>19</u> Hours <u>61</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Denver, Col.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Russell Holman Snead</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1673</u>	
17. INFORMANT <u>Mrs. Geo. Giguere (Sister)</u>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO		<u>Acute MYOCARDIAL INFARCTION</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		<u>ARTERIO SCLEROTIC C.V. DISEASE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>APRIL 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>APR 15</u> 1961 , and that death occurred at <u>4:15 A</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>DeWitt E. DeLawter</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLawter</u>		22d. ADDRESS <u>3848 Porter Street, N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company-2901 14th St., N.W.</u>		25a. REC'D BY REGISTRAR <u>DATE APR 17 '61</u>	
<u>Washington 9, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

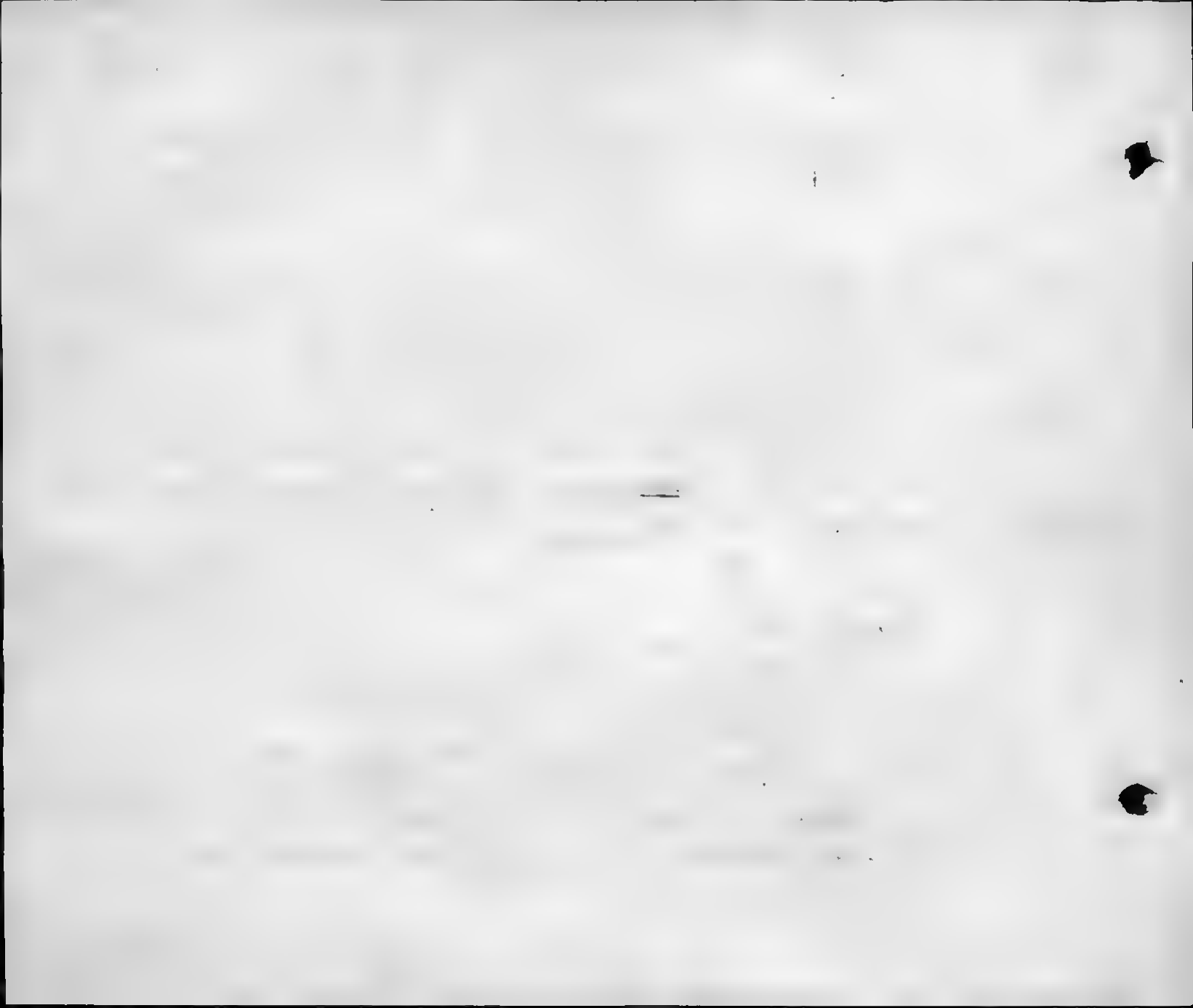
CERTIFICATE OF DEATH

Item 2 Film G282

4/24/61 iwk

04555

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u> d. STREET ADDRESS <u>908 Davis Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Henry Franz Schubert</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-68</u>	
9. AGE (in years last birthday) <u>92 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>10</u>	
11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Graf</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Washington San. + Hosp. Tak. Park, Md.</u>		Address <u>Washington San. + Hosp. Tak. Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>?</u>	
20c. TIME OF INJURY Month, Day, Year <u>3-26-1961</u> Hour a.m. <u>4-14-1961</u> p.m. <u>4:10pm</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>?</u>		20f. (City or town) <u>?</u> (County) <u>?</u> (State) <u>?</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3-26-1961</u> to <u>4-14-1961</u> that (I) (we) last saw the deceased alive on <u>4-14-1961</u> and that death occurred at <u>4:10pm</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Aldo Vacca</u>		22b. DATE SIGNED <u>4-14-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aldo VACCA</u>		22d. ADDRESS <u>1429 University Blvd., W. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 18-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Adamsburg, Md. 26816</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hines</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>APR 19 '61</u>	



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

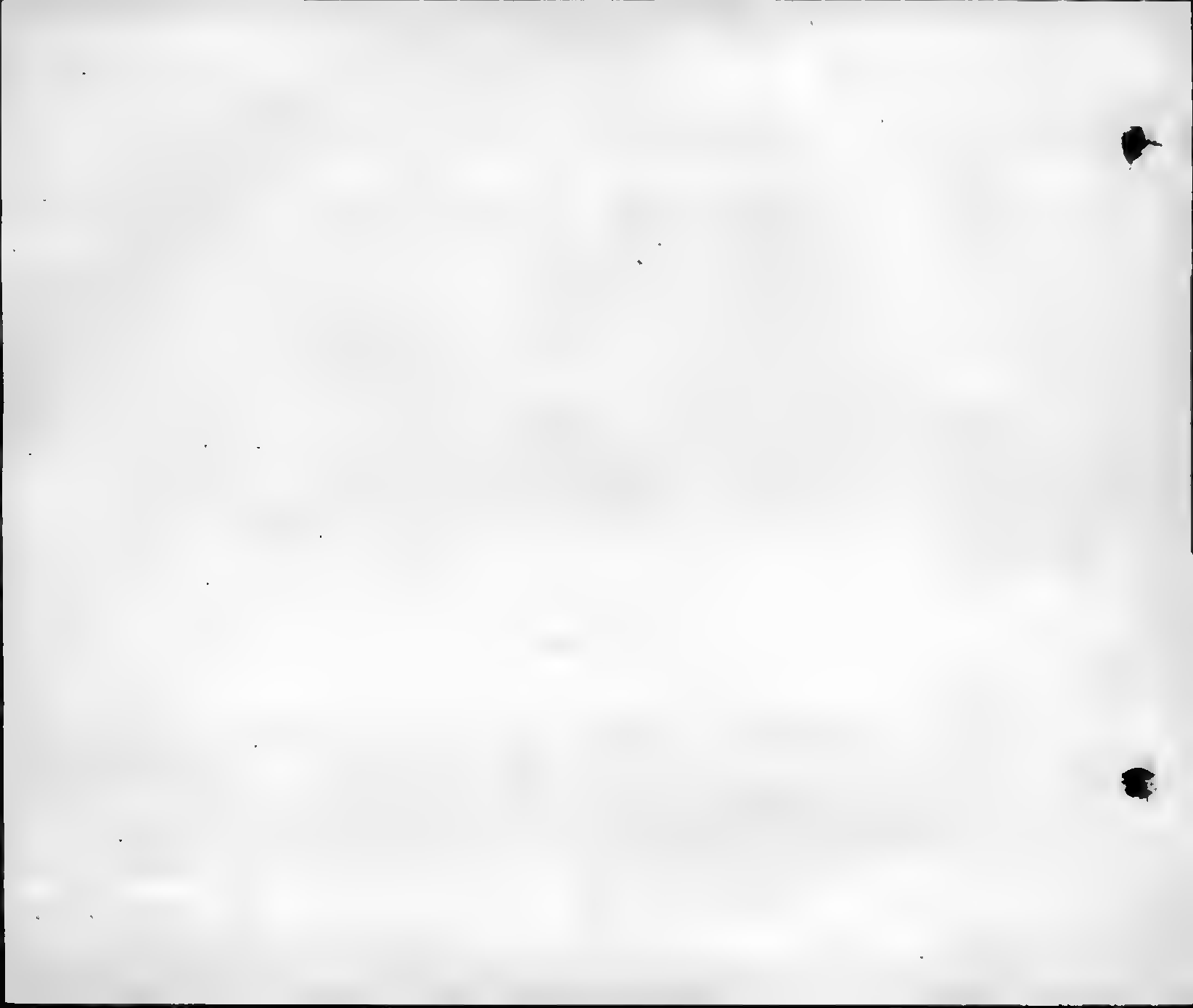
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04556

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived IF institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Albany Avenue Oakhaven Convalescent Home				d. STREET ADDRESS 9328 Wilmer Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Edith Middle R Last Schutt				4. DATE OF DEATH Month April Day 24 Year 1961			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1891	
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 6 Days 2 Hours 1 Min.		11. IF UNDER 24 HRS. Months 6 Days 2 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Frye				14. MOTHER'S MAIDEN NAME Clara Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Ma Evelyn Smith Address 9328 Wilmer St. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diseases							
322 X DUE TO Cerebral thrombosis & embolism							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Intercurrent infection & pneumonia & fever							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Probable severe anemia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/20/1961 to 4/24/1961 , that (I) (we) last saw the deceased alive on 4/23/1961 , and that death occurred at 15:41 AM, from the causes and on the date stated above.							
22a. SIGNATURE H. H. Vol. 1010				22b. DATE SIGNED APR 25 '61			
22c. PHYSICIAN'S NAME (Type) Has H. Vol. 1010				22d. ADDRESS 301 Underwood St NW Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/27/1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. H. Vol. 1010				25a. REC'D BY REGISTRAR APR 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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4567

CERTIFICATE OF DEATH

Reg. Dist. No. 04557

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10201 Darnestown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERT T. SCHWARTZBECK First Middle Last				4. DATE OF DEATH April 26, 19 61 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4/28/1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Edward T. Schwartzbeck				14. MOTHER'S MAIDEN NAME Susan J. Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address C. Raymond Schwartzbeck - Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) carcinomatosis DUE TO (c) carcinoma of stomach						INTERVAL BETWEEN ONSET AND DEATH 1 min. 6 min. 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/11/1961 to 4/26/1961 , that I last saw the deceased alive on 4/26/1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above							
ACTUAL SIGNATURE Stephen M. Jones M.D.				ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 4/26/61			
PHYSICIAN'S NAME (Type) Stephen Jones - Rockville, Maryland							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/61		22c. NAME OF CEMETERY OR CREMATORY St. Marys		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Funeral Home-1331 E. Montg. Ave Rockville, Maryland				24a. REC'D BY REGISTRAR MAY 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thrash	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G432 4/21/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 04558

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>San</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leansington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leansington Gardens Sanatorium</u>		d. STREET ADDRESS <u>07X-2</u>	
3. NAME OF DECEASED (Type or print) <u>MARJORIE ANN SEEDERS</u>		4. DATE OF DEATH <u>APRIL 15 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 June 1912</u>
9. AGE (In years last birthday) <u>49 1/2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Bullock</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Philpot</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450 Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerosis - Coronary</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/21/61</u> , 19 <u>61</u> , to <u>4/1/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/1/61</u> , 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Samuel Allen M.D.</u>		PHYSICIAN'S NAME (Type) <u>Allen (SAM)</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>4-16-61</u>	<u>Leansington</u>	<u>Leansington Del</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home 4812 So. Lee Hwy</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

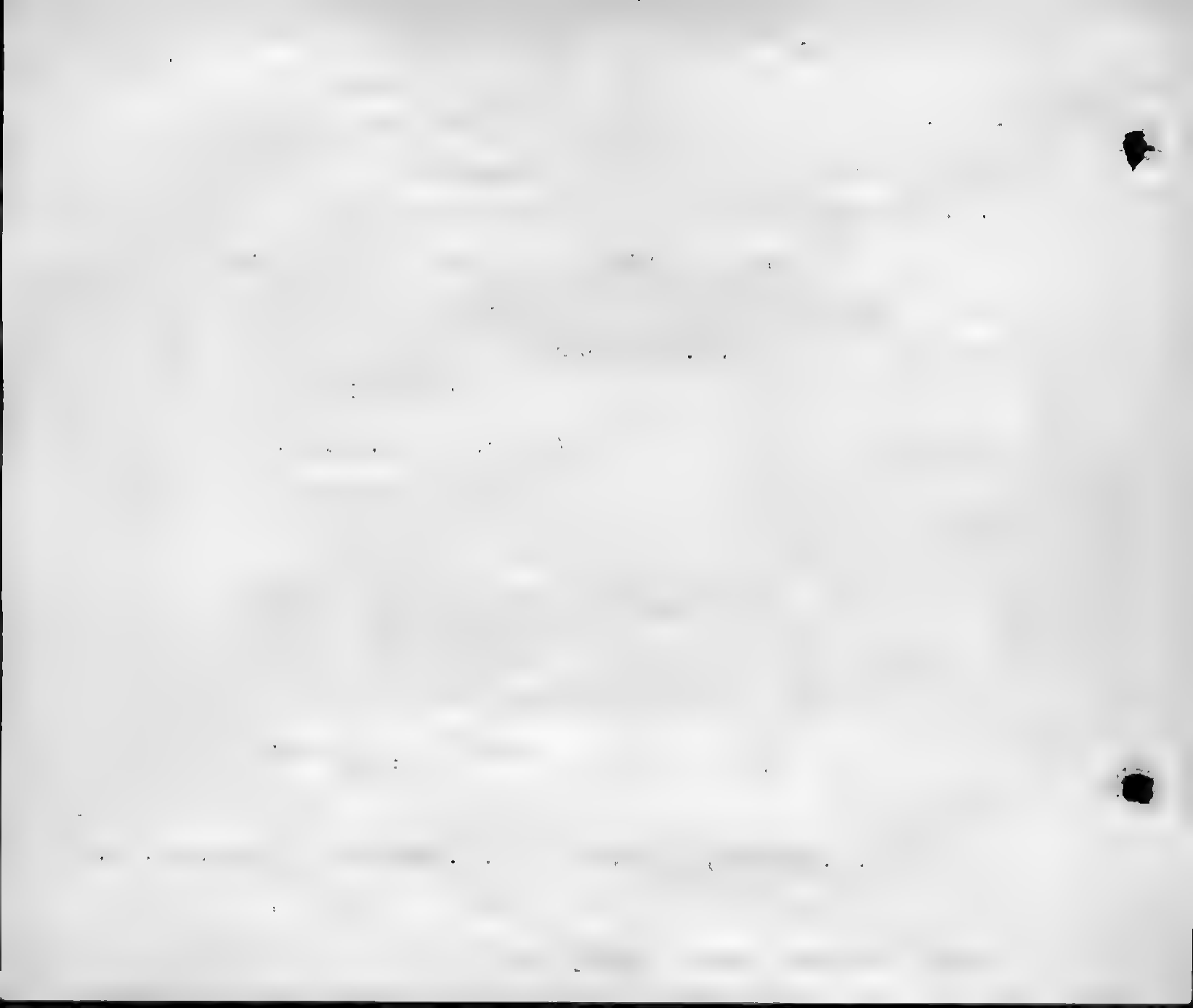
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4569

04553

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN 1b 47 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Pennsylvania		f. COUNTY Carlisle	
3. NAME OF DECEASED (Type or print) Glenn Orville SEIDER		4. DATE OF DEATH April 26 19 61		a. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5-4-01		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps		11. BIRTHPLACE (County & State, or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles SEIDER		14. MOTHER'S MAIDEN NAME Margaret TOOLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes 1921 to 1951		16. SOCIAL SECURITY NO 161-32-5048		17. INFORMANT (W) Mrs. Alice D. Seider, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal aortic aneurysm with rupture 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from March 10 19 61 to April 26 19 61 that (X) (we) last saw the deceased alive on April 26 1961 and that death occurred at 11:15 PM from the causes and on the date stated above.					
22a. SIGNATURE K. V. Harshman		22b. DATE SIGNED 4-27-61		22c. PHYSICIAN'S NAME (Type) K. V. HARSHMAN, LT, MC, USN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington		23e. (State) Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Lutz Hoffman Funeral Home National Capital, Pa.	
25a. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kinas			



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

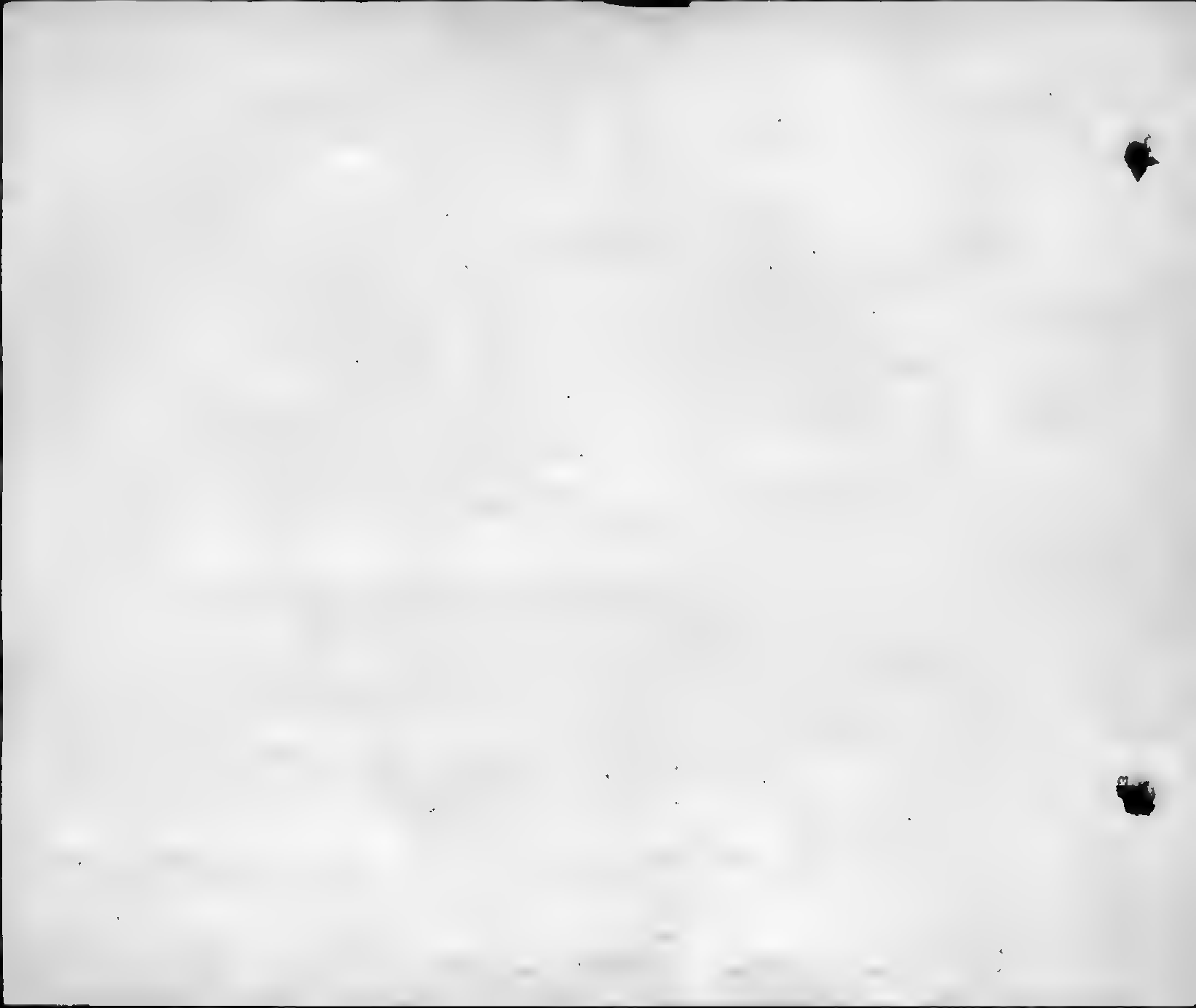
4580

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04560

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GAITHERSBURG</u> d. STREET ADDRESS <u>1 Rt. 3 Box 179</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLE ARTHUR Shirley</u>				4. DATE OF DEATH <u>10</u> <u>PM</u> <u>April</u> <u>15</u> <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 27 1912</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>odd jobs</u>		11. BIRTHPLACE (County & State or foreign country) <u>DARNESTOWN MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES HENRY Shirley</u>				14. MOTHER'S MAIDEN NAME <u>CORA Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>219-01-9081</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Active pulmonary tuberculosis</u> DUE TO <u>U & X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>None</u> (b) <u>None</u> DUE TO <u>None</u> (c) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 15 1961</u> to <u>April 15 1961</u> that (I) last saw the deceased alive on <u>April 15 1961</u> and that death occurred at <u>11</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Allen J. Neill</u>				22b. DATE SIGNED <u>April 15 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>8601 old Georgetown Road, Bethesda 14 Maryland</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove, Rockville Md</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robt. H. Snowsen</u>				25a. REC'D BY REGISTRAR <u>APR 20 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				25c. DATE			

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

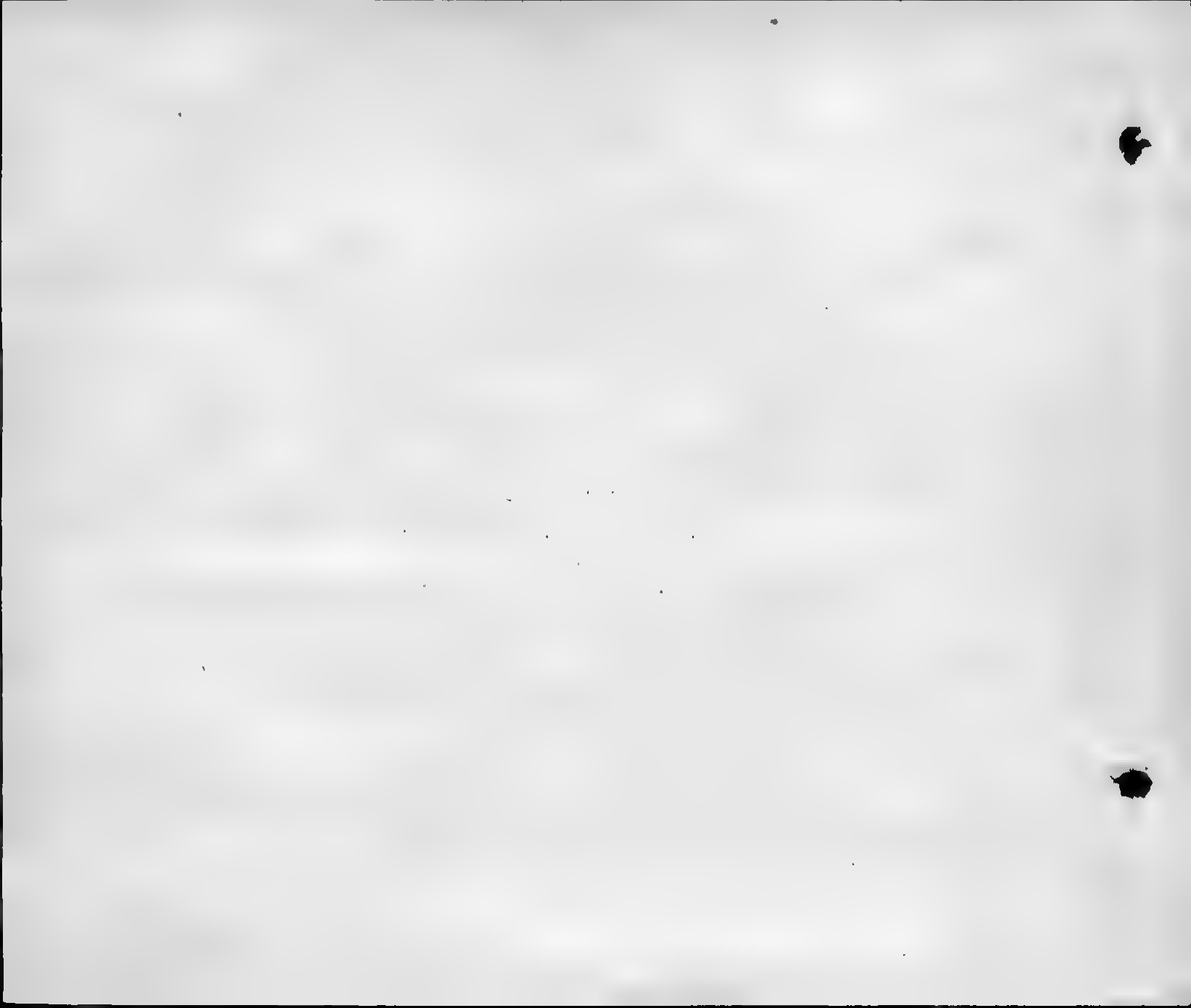
VII. A15ME
5M 7/59

1
MONTGOMERY
TAKOMA PARK
WASH. SANITARY HOSPITAL
MORRIS (JIM)
SIRMAI
7-2-1842
HUNGARY
JESSIE
ALBERT SIRMAI
ARL. VA.
5-8 days
NATURAL CAUSES
G. W. LEW
GOLDEN JOURNAL HOME-4217-9-1111
APR 20 '61
ARTHUR S. KRAMER

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04561

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SANITARY HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>8231 14th Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>MORRIS (JIM) SIRMAI</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1941</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>7</u> Day <u>2</u> Year <u>1842</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minionist (Ret)</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	
13. FATHER'S NAME <u>Samuel Sirmai</u>		14. MOTHER'S MAIDEN NAME <u>Jessie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>476-01-2457</u>	
17. INFORMANT <u>ALBERT SIRMAI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial septal infarct with mural thrombosis</u> DUE TO (b) <u>Severe coronary atherosclerosis with recent coronary thrombosis.</u> DUE TO (c) <u>Post op. status (22 days) from suprapubic proctectomy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/19/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>G.W. Lew</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md</u>	
22e. FUNERAL DIRECTOR <u>Golden Journal Home-4217-9-1111</u>		22f. ADDRESS	
24a. REC'D BY REGISTRAR <u>APR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kramer</u>	

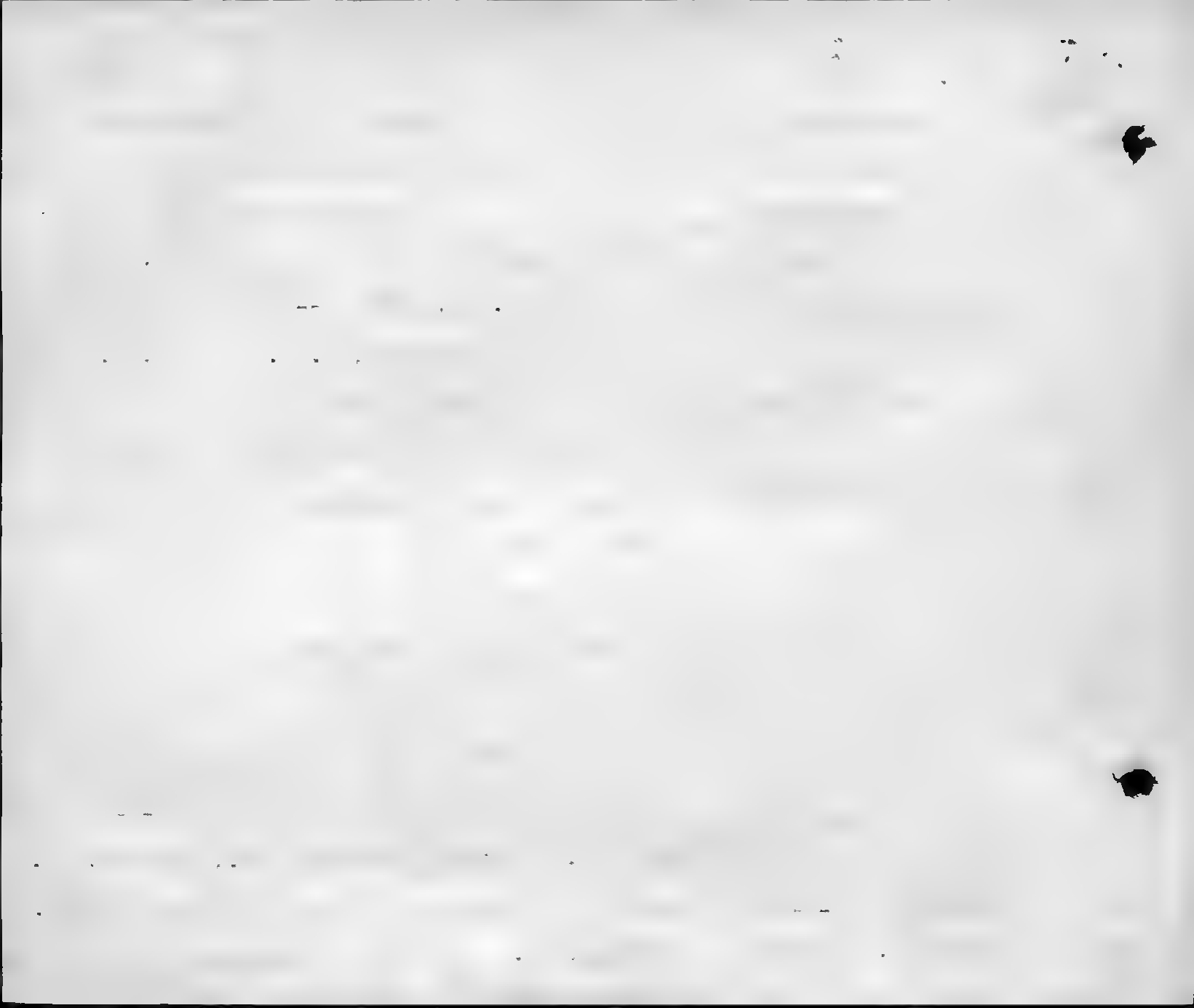
DATE SIGNED Apr. 18-1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4572											
04562											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b. 5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5814 Ogden Court						2. USUAL RESIDENCE (Where deceased lived, if last 12 months; Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5814 Ogden Court					
3. NAME OF DECEASED (Type or print) LARS ARNOLD SITES						4. DATE OF DEATH Month April Day 7 Year 1961					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH Oct. 20, 1960					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None						11. BIRTH-PLACE (County & State, or foreign country) Washington, D. C.					
13. FATHER'S NAME James Neil Sites						14. MOTHER'S MAIDEN NAME Inger Krogh					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No						16. SOCIAL SECURITY NO. None					
17. INFORMANT father						Address Same as Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Respiratory Obstruction (mucous) DUE TO (c) Mongoloid and malnutrition											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year 19											
20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Feb 20, 1961 to April 7, 1961 , that (I) last saw the deceased alive on March 23, 1961 , and that death occurred at 3 AM , from the causes and on the date stated above.											
22a. SIGNATURE Frank Y. Jagers, Jr. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4-7-61											
22c. PHYSICIAN'S NAME (Type) FRANK Y. JAGGERS, JR. 22d. ADDRESS 5707 Wisconsin Ave., Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 4-8-61 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 23d. LOCATION (City, town or county) (State) Prince George County, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md. 25a. REC'D BY REGISTRAR APR 12 '61 25b. REGISTRAR'S SIGNATURE Robert S. Kraus											



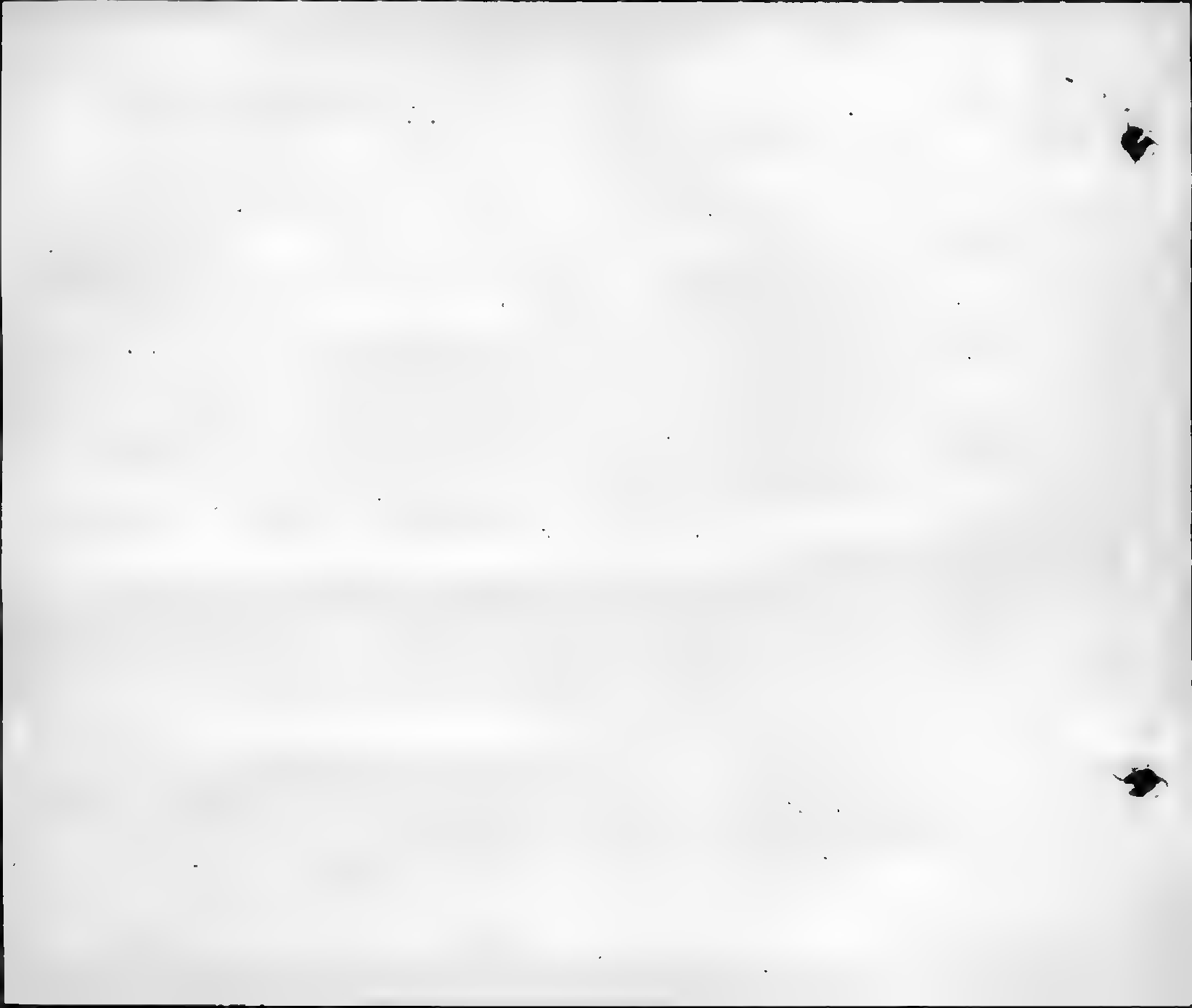
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

21
4573
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04563

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3008 McKinley Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>B</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28th, 1871</u>
9. AGE (In years last birthday) <u>89</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>3</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Parking Garage</u>	
11c. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>	
17. INFORMANT <u>George W. Weigold - 3008 McKinley St. NW - DC</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral, acute pontine</u> 54001 DUE TO <u>not OR - closure perforated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>peptic ulcer</u> DUE TO (c) <u>peptic ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21 I certify that (I) (this hospital) attended the deceased from <u>4/8</u> 19 <u>61</u> to <u>4/11</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>4/11</u> 19 <u>61</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R.C. Myers</u>		22b. DATE SIGNED <u>4/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.C. Myers</u>		22d. ADDRESS <u>8512 Old Georgetown Rd. Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 4/15/61</u>		23b. DATE THEREOF <u>4/15/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chester Rual Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chester, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>DATE APR 13 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony S. Evans</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

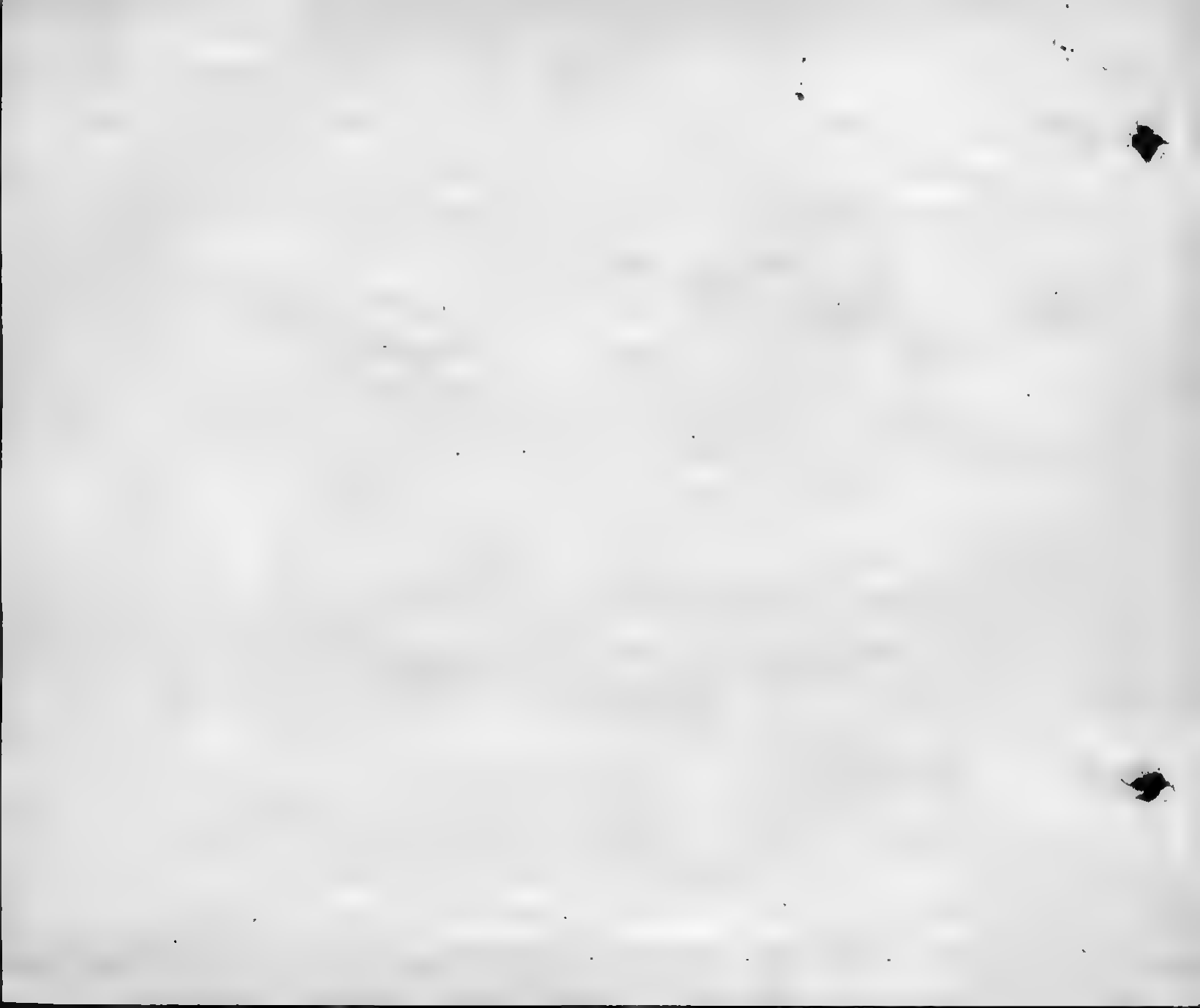
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4574

CERTIFICATE OF DEATH

04564

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7005 East Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7005 East Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Crystal Smith</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 14, 1909</u>		9. AGE (In years, if under 1 year; if under 24 hours, last birthday) <u>51</u> yrs. <u>8</u> months <u>27</u> days		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tennessee</u>		11. PLACE OF BIRTH <u>Tennessee</u>	
13. FATHER'S NAME <u>Amzi Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Crystal</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW 1</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Paula H. Smith-Wife-same 2d</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (c), stating the underlying cause last. DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>Unk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>9</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>1954 to 4/11/1961</u>		20g. (County) <u>Montgomery</u>		20h. (State) <u>Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/1/1954</u> to <u>4/11/1961</u>, that (I) (we) last saw the deceased alive on <u>4/10/1961</u>, and that death occurred at <u>4:15 AM</u>, from the causes and on the date stated above.					
22a. SIGNATURE <u>George Sharpe</u>		22b. DATE SIGNED <u>4/11/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		22d. ADDRESS <u>10511 Summit Ave Kensington Md</u>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Cremation 4/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u>		25a. REC'D BY REGISTRAR <u>APR 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	



1
 TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04565

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4330 Yuma St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>Dillon</u> <u>Snider</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>19</u> - Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-19</u>
9. AGE (In years last day) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - realtor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Z. T. Dillon</u>		14. MOTHER'S MAIDEN NAME <u>Tennessee Haynie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-28-47</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute antero-septal myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> <u>1961</u> to <u>4-19</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>4-19</u> <u>1961</u> , and that death occurred at <u>8:15</u> <u>A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Youngblood</u>		22b. DATE SIGNED <u>4-21-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Youngblood</u>		22d. ADDRESS <u>Washington Clinic - D. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>4/20/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	23d. LOCATION (City, town or county) <u>Huntington, West Virginia</u> (State) <u> </u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		25. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	

APR 21 '61

C. Star & Knecht



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04566

4576

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>13208 Ferndale Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>J.</u> Last <u>Spille</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 16, 1882</u>
9. AGE (in years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wilke</u>		14. MOTHER'S MAIDEN NAME <u>Matilda (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wilmer P. Scheer</u>		Address <u>(same as above)</u>	
18. CAUSE OF DEATH (Enter only one cause put line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Separation of Anzstomoses</u> DUE TO (c) <u>Gastric Resection for Bleeding duodenal Ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 d</u> <u>10 d</u> <u>10 d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (GIVEN IN PART I) (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1961</u> to <u>April 4, 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>April 4, 1961</u> , and that death occurred at <u> </u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Bernton</u>		22b. DATE SIGNED <u>4/4/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton, M.D.</u>		22d. ADDRESS <u>4743 Bradley Blvd (Hollywood)</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial-transit 4/4/61</u>	23b. DATE THEREOF <u>4/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Port Wash. Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Port Washington, Wisconsin</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25. REC'D BY REGISTRAR <u>APR 6 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

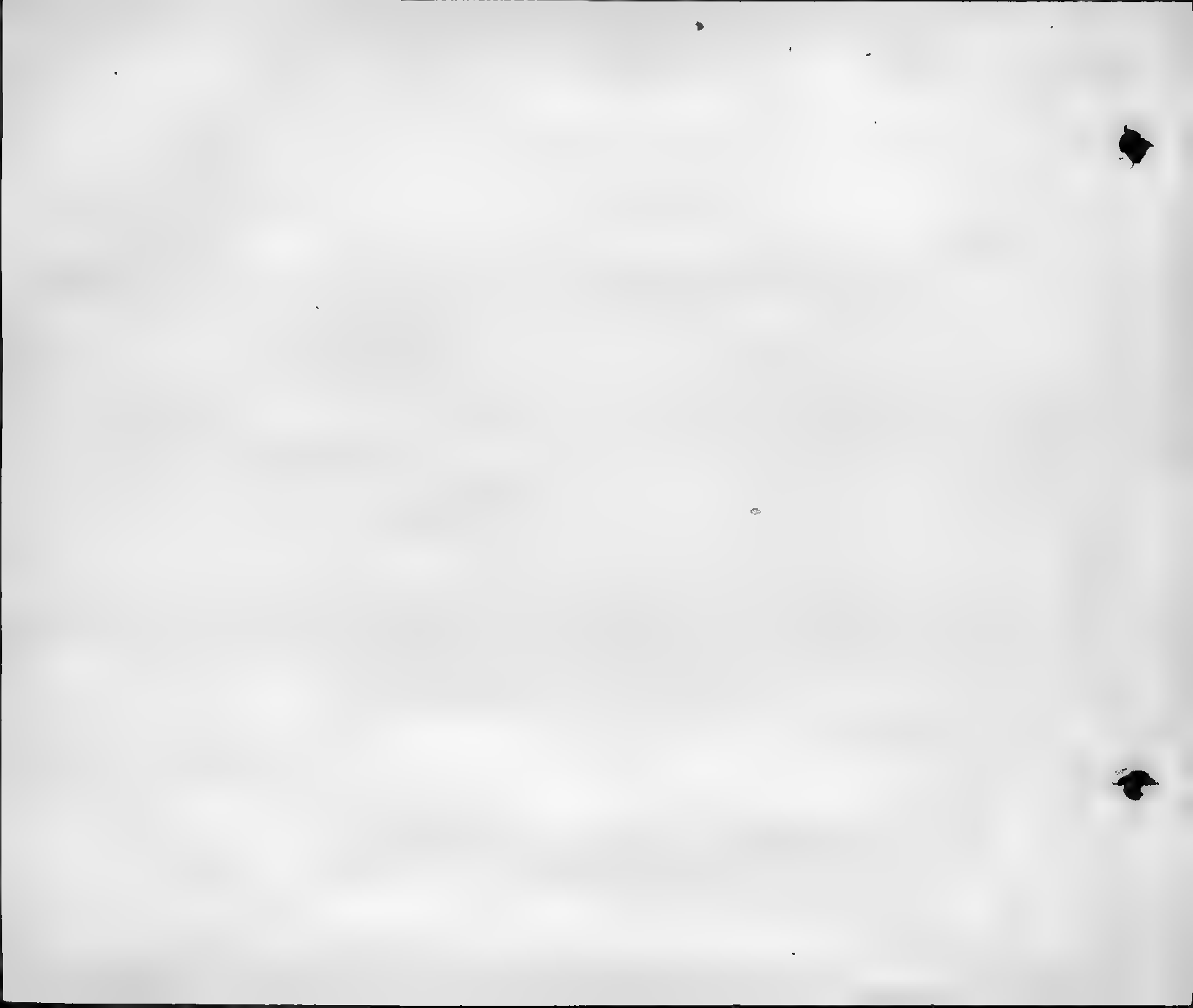
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4577

04567

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Res. dnce before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u></p>			
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tarom Park</u></p>				<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San & Hosp</u></p>				<p>e. STREET ADDRESS <u>11330 Kara La.</u></p>			
<p>3. NAME OF DECEASED (Type or print) <u>Josephine Kenville Stallone</u></p>				<p>4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1961</u></p>			
<p>5. SEX <u>F</u></p>		<p>6. COLOR OR RACE <u>W</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>1-8-86</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>9. AGE (In years - last birthday) <u>75</u> yrs.</p>		<p>11. BIRTHPLACE (State or foreign country) <u>Vermont</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>				<p>13. FATHER'S NAME <u>UNKNOWN</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p>			
<p>16. SOCIAL SECURITY NO. <u>MRSCIVITA Gamble</u></p>				<p>17. INFORMANT Address <u>Same as deceased</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) _____ (County) _____ (State) _____</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <u>Frank J. Broschant</u></p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u></p>				<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>				<p>DATE SIGNED <u>4-11-61</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify)</p>		<p>22b. DATE THEREOF <u>April 14, 1961</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHN'S CHURCH CEM.</u></p>		<p>22d. LOCATION (City, town, or county) <u>ACCOKEEK</u></p>	
<p>23. FUNERAL DIRECTOR <u>Arthur S. Evans</u></p>				<p>24a. REC'D BY REGISTRAR <u>APR 13 '61</u></p>			
<p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u></p>				<p>24c. ADDRESS <u>254 Garrold St. N.W. D.C.</u></p>			

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4578

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04568

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE D.C. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b D.O.A			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 5807 Devonshire Road Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle E Last Stephens				4. DATE OF DEATH Month April Day 29 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 14 1896		9. AGE (In years last birthday) 64 yrs	10. UNDER 1 YEAR Months 1 Days 15 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Memphis, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME William Stephens				14. MOTHER'S MAIDEN NAME Mary Louise Robinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-32-6242		17. INFORMANT Address Same as above Mrs. Alfred Malboruf (Daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) 4-2-1 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Septal myocardial infarct on 9-2 April 61							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Septal myocardial infarct on 9-2 April 61							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 April 1961 to 29 Apr 1961 , that (I) (we) last saw the deceased alive on 27 Apr 1961 and that death occurred at 2 PM , from the causes and on the date stated above							
22a. SIGNATURE Herbert M. Martyn Jr.				22b. DATE SIGNED 29 Apr 61		22c. PHYSICIAN'S NAME (Type) Herbert Martyn Jr.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 5/1/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION (City, town, or county) (State) Suitland, Maryland				25a. REC'D BY REGISTRAR DATE MAY 3 '61		25b. REGISTRAR'S SIGNATURE Carlton S. Kraus	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				24b. ADDRESS Bethesda, Maryland		24c. NAME OF FUNERAL HOME L.H. Humphrey Funeral Home	

Dr. Brodard Notarified



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TSM 9/59

4579

4563

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 19 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE South Carolina b. COUNTY Greenville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenville d. STREET ADDRESS 20 McDade Street e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Levis Middle Odell Last Stone		4. DATE OF DEATH Month April Day 28 Year 19 61	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1907
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Worker		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11 BIRTHPLACE (State or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Stone		14. MOTHER'S MAIDEN NAME Belle Woodall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 247-01-1150	
17. INFORMANT The Medical Record Address National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Open Heart Surgery DUE TO (b) Rheumatic Heart Disease with Aortic Stenosis DUE TO (c) Arterioneophiosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 16 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from April 9, 19 61 to April 28, 19 61 that (I) (we) last saw the deceased alive on April 28, 19 61 and that death occurred at 12:40PM from the causes and on the date stated above			
22a. SIGNATURE Benson R. Wilcox		22b. DATE SIGNED 4-28-61	
22c. PHYSICIAN'S NAME (Type) Benson R. Wilcox M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial-transit	23b. DATE THEREOF 4-29-61	23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery	23d. LOCATION (City, town, or county) (State) Greenville, South Carolina
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE MAY 3 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

(M)

(I)



4580

CERTIFICATE OF DEATH

Reg. Dist. No.

04570

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Silver Spring, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8031-Eastern Avenue, S.S., Md.		d. STREET ADDRESS 8031-Eastern Avenue	
3. NAME OF DECEASED (Type or print) First JEANNETTE Middle P. Last STRANLEY		4. DATE OF DEATH Month APRIL Day 25 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1882
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 3 Days 18 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hudson Pettit		14. MOTHER'S MAIDEN NAME Mary Pettit.....	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph H. Stranley		Address 4916-Leisure Drive, Temple Hills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Colon 153-8 DUE TO Carcinoma Colon (Rectal) 1960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Oct , 19 60 , to 24 Apr , 19 61 , that I last saw the deceased alive on 27 Apr , 19 61 , and that death occurred at 6:04 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1011 Univ. Blvd., Silver Spring, Md. DATE SIGNED Apr 25, 1961			
ACTUAL SIGNATURE Thomas P. Fogarty, M.D.			
PHYSICIAN'S NAME (Type) Thomas P. Fogarty, 1011-University Blvd., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/28/1961	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE HYSOY'S FUNERAL HOME		24a. REC'D BY REGISTRAR DATE APR 26 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

2581
MONTGOMERY
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04571

1. PLACE OF DEATH
a. COUNTY **MONTGOMERY**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **BETHESDA**
c. LENGTH OF STAY IN 1b **20 hrs.**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **SUBURBAN**

2. USUAL RESIDENCE (Where deceased lived; If institution; Residence before admission)
a. STATE **Ma**
b. COUNTY **Montgomery**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Summer**
d. STREET ADDRESS **5608 Wood May**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **JAMES D. STUDLEY**
4. DATE OF DEATH **APRIL 21 19 61**
5. SEX **Male**
6. COLOR OR RACE **White**
7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH **9/26/92**
9. AGE (In years last birthday) **68** yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired - Wood Technologist**
10b. KIND OF BUSINESS OR INDUSTRY **IOWA**
11. BIRTHPLACE (State or foreign country) **U.S.A**
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **William Judson STUDLEY**
14. MOTHER'S MAIDEN NAME **Annette LILLIE**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO**
16. SOCIAL SECURITY NO. **579-32-0561**
17. INFORMANT **RUTH E. STUDLEY (WIFE) SAME AS ABOVE**
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cerebral Infarction as a result of**
901.0 DUE TO **Fall**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO **Cerebral Infarction, left frontal (14) cerebral hemorrhage**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).
INTERVAL BETWEEN ONSET AND DEATH **3-4 days**

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

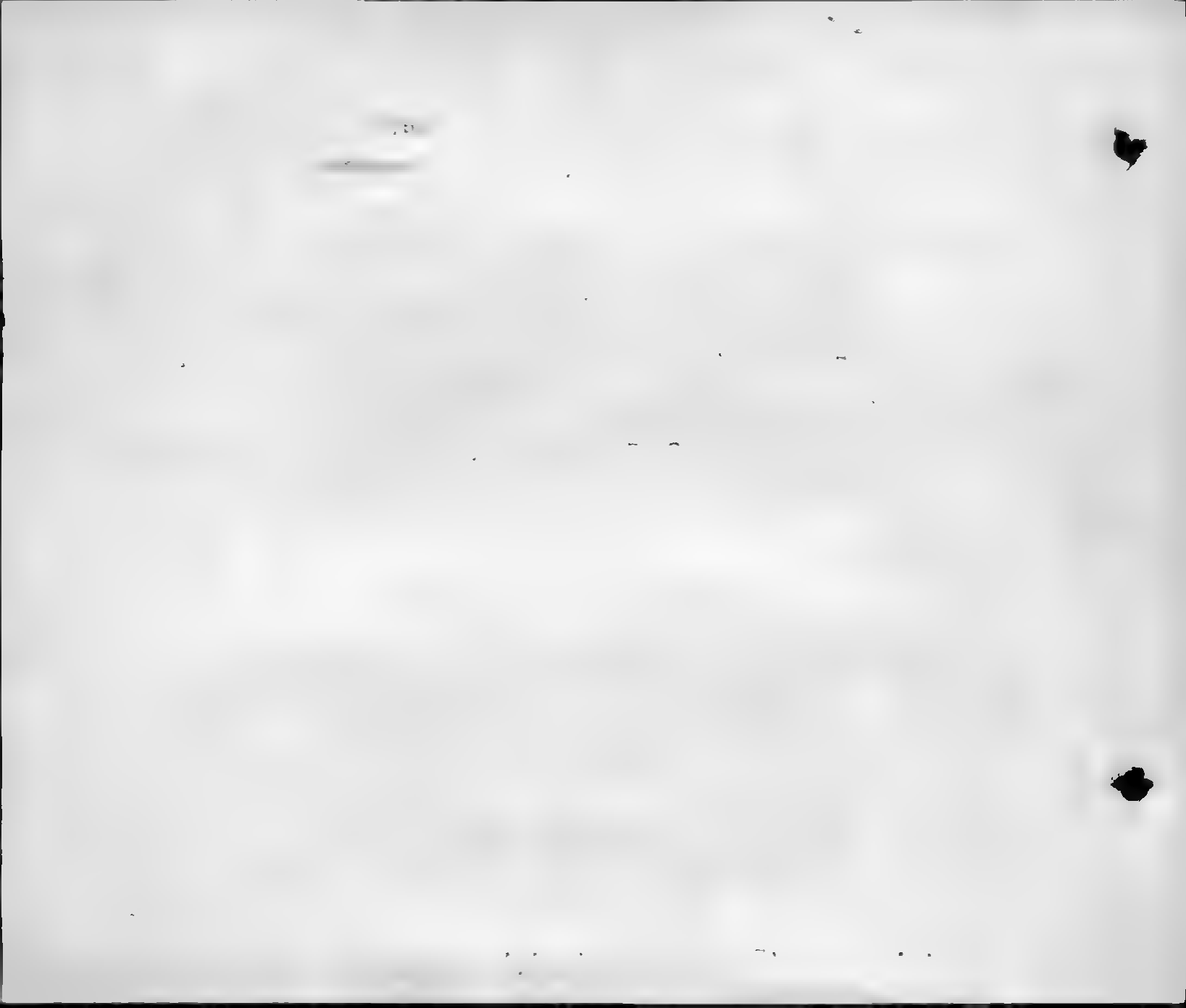
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Reported to have fallen from ladder**
20c. TIME OF INJURY Month, Day, Year **11:30 a.m. 7-20 1961**
20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) **Home**
20f. (City or town) (County) (State) **Washington DC.**

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ACTUAL SIGNATURE **Frank J. Bruchart** M.D. ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **FRANK J. BRUCHART** DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED **4-21-61**
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
22b. DATE THEREOF **4/24/61**
22c. NAME OF CEMETERY OR CREMATORY **Parklawn Cemetery**
22d. LOCATION (City, town, or country) (State) **Montgomery County, Maryland**

23. FUNERAL DIRECTOR **The S.H. Hines Co. - 2901 14th St. N.W.**
ADDRESS **Washington 9, D.C.**
24a. REC'D BY REGISTRAR **APR 24 '61**
24b. REGISTRAR'S SIGNATURE **Arthur S. Hines**



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

4582

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

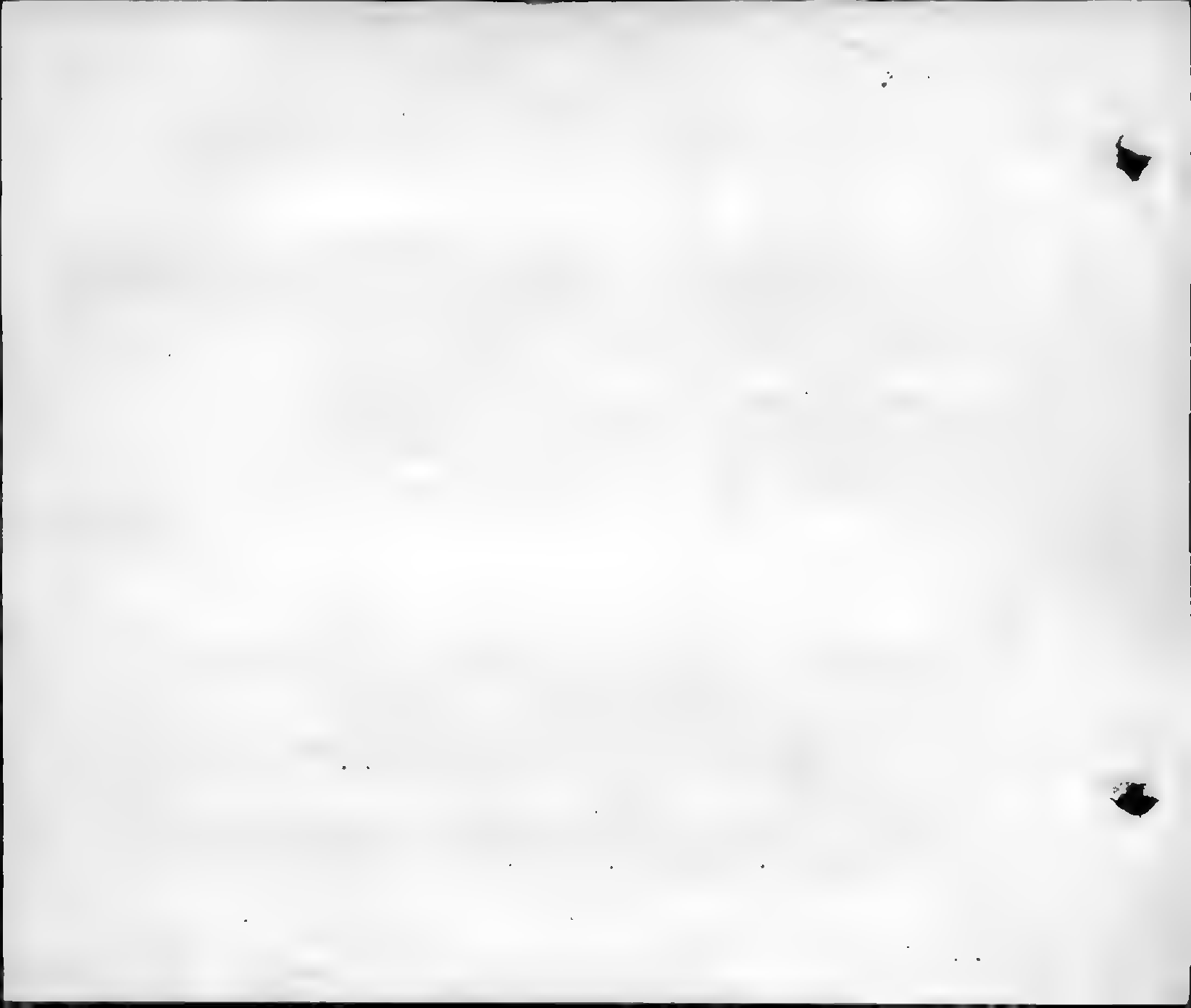
04574

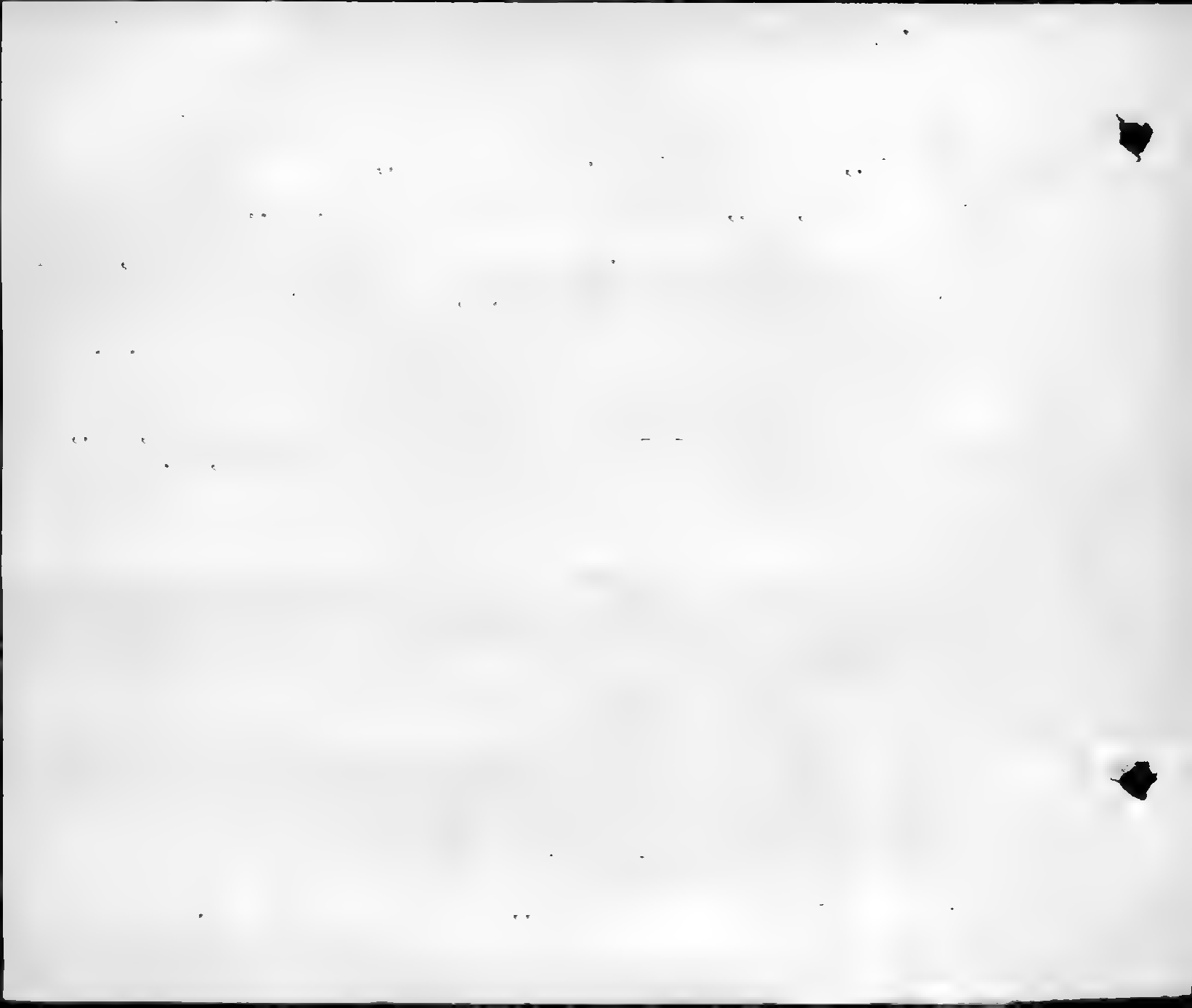
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b (2)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) EDITH ELIZABETH STULL		4. DATE OF DEATH APRIL 15 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-89
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN XXXXXXXX Leishear		14. MOTHER'S MAIDEN NAME ELIZABETH CHALK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Toxic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Bronchopneumonia DUE TO (b) 5 days (c) 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular accident with left hemiplegia - 1 month INTERVAL BETWEEN ONSET AND DEATH 12 hours			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 9, 1948 to April 15, 1961 , that (I) was lost saw the deceased alive on April 14, 1961 , and that death occurred at 9:24 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker M.D.		22b. DATE SIGNED 4/15/61	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.		22d. ADDRESS CLARKSVILLE, MD.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 4-18-61	23c. NAME OF CEMETERY OR CREMATORY Emmanuel	23d. LOCATION (City, town, or county) (State) Scaggsville, Md
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR APR 18 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

(M)

(I)

MEDICAL CERTIFICATION





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

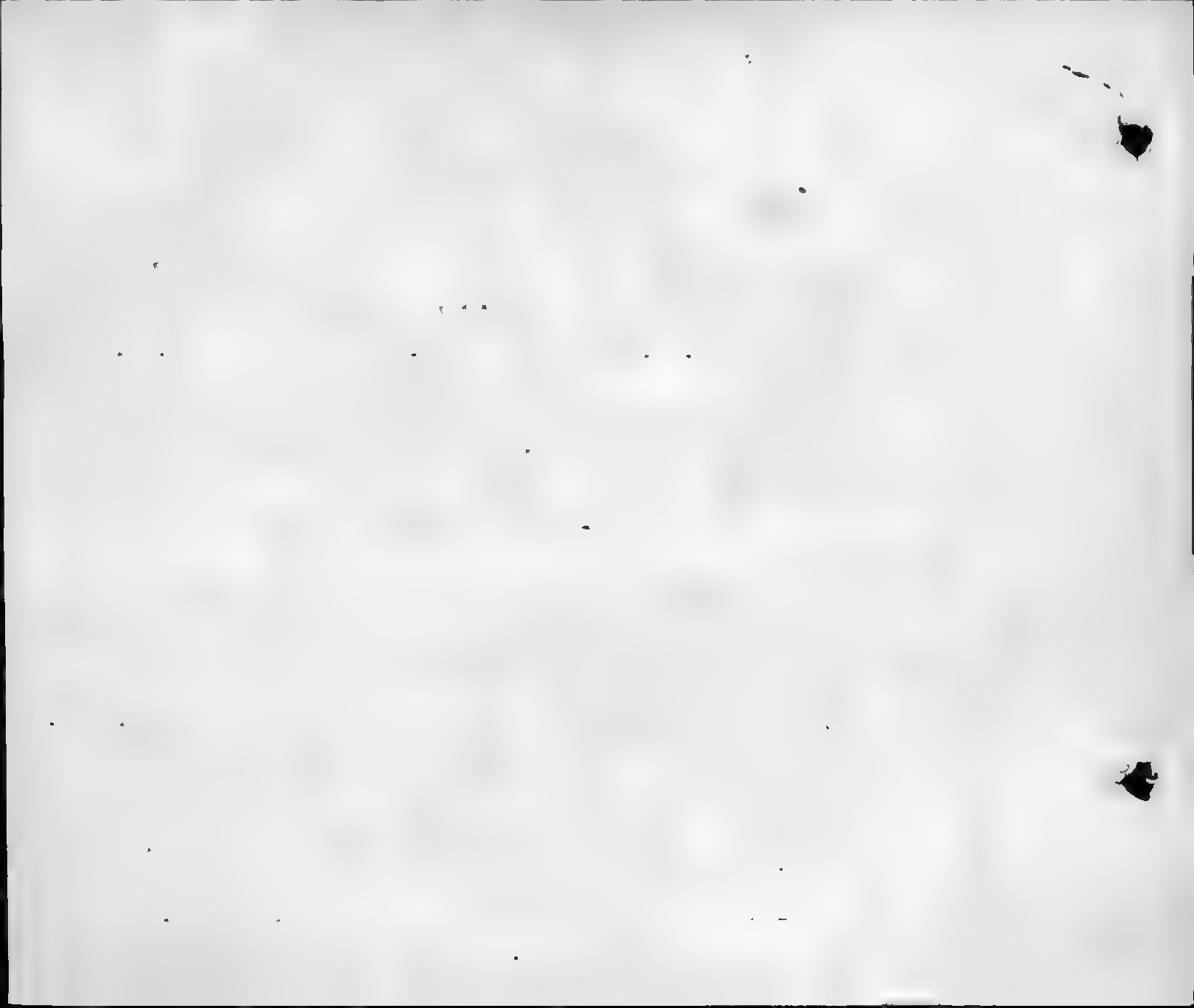
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04574

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b minutes		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elmhurst Parkway		d. STREET ADDRESS 4413 Everett Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MATTIE Middle MALINDA Last SUMMERS		4. DATE OF DEATH Month April Day 5 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1918
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 42 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Supply		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt MIT	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lemmie Summers		14. MOTHER'S MAIDEN NAME K Zella McGill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Sister		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic Hemorrhage DUE TO Bullet wound in left chest (heart) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) self inflicted bullet wound in left chest DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) self inflicted bullet wound in left chest	
20c. TIME OF INJURY Month, Day, Year 3:50 p. m. 4/5/61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, etc.) street	20f. (City or town) Kensington (County) Montg. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 4-6-61	
22c. NAME OF CEMETERY OR CREMATORY White Oak Cemetery		22d. LOCATION (City, town, or county) Oakdale, Tenn. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DATE APR 10 '61	
24b. REGISTRAR'S SIGNATURE William S. Howard			

2



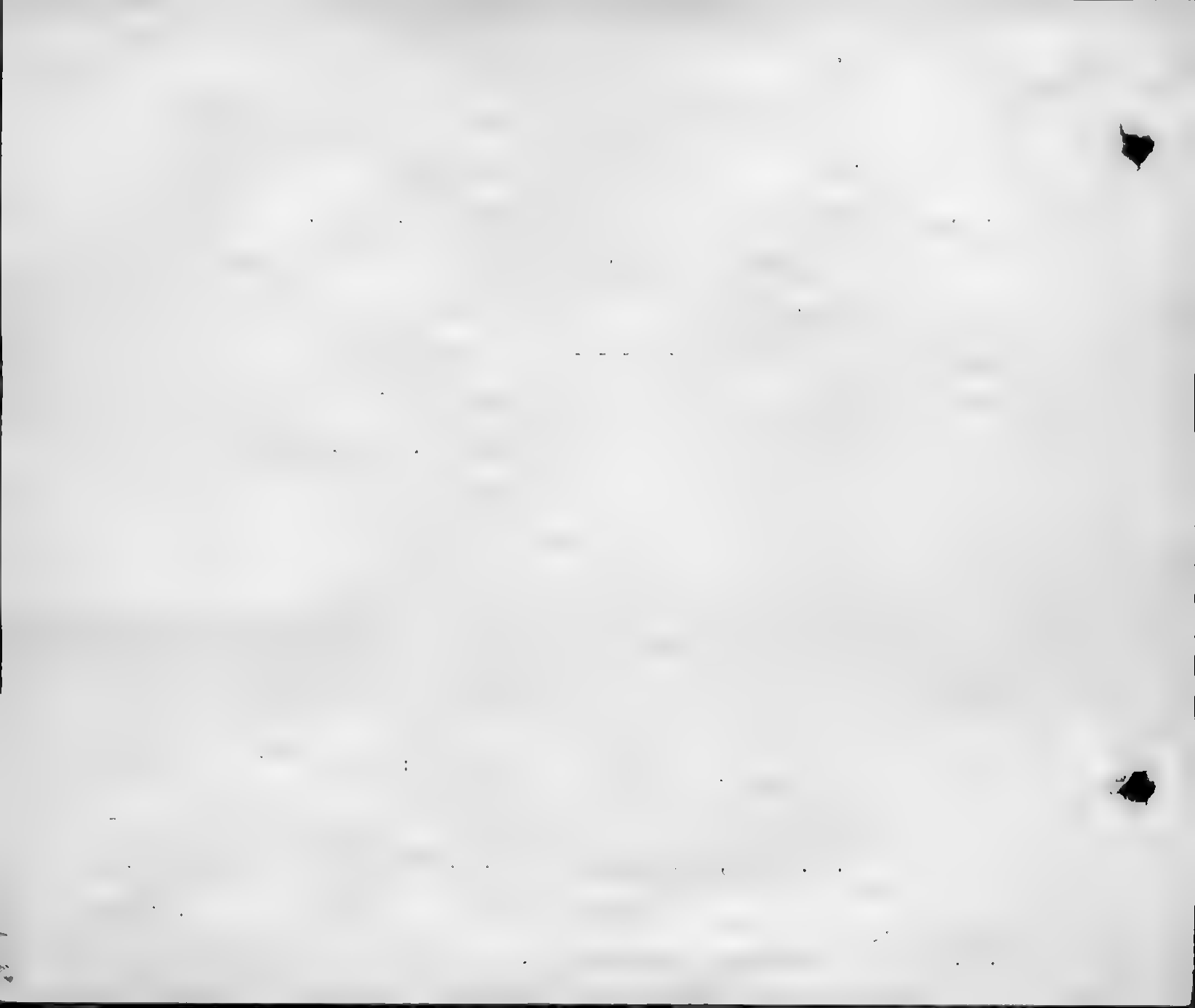
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery Co. Deputy Medical Examiner notified & released to hospital.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		a. STATE Maryland		b. COUNTY Montgomery	
c. LENGTH OF STAY IN Institution DOA		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 4709 Bradley Blvd.	
3. NAME OF DECEASED (Type or print) Pauline Gertrude SWEET		4. DATE OF DEATH April 25 1961		5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-21-96		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tennessee		11. BIRTHPLACE (Country & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Cumings		14. MOTHER'S MAIDEN NAME Bessie Harding		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (S) Richard B. Sweet, same as #2 above	
17. INFORMANT (S) Richard B. Sweet, same as #2 above		18. CAUSE OF DEATH [Enter on only one cause pertaining to (a), (b), and (c)] Cor pulmonale acute Branchial asthma		19. INTERVAL BETWEEN ONSET AND DEATH 30 minutes 6 years		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 16, 1957 to April 24, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 24, 1961 , and that death occurred at 7:50AM , from the causes and on the date stated above.		22a. SIGNATURE J. M. Young, Lt, MC, USN	
22b. DATE SIGNED 4-25-61		22c. PHYSICIAN'S NAME (Type) J. M. Young, Lt, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 5-1-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia		24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumpfrey	
24a. ADDRESS R. A. Pumpfrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR APR 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

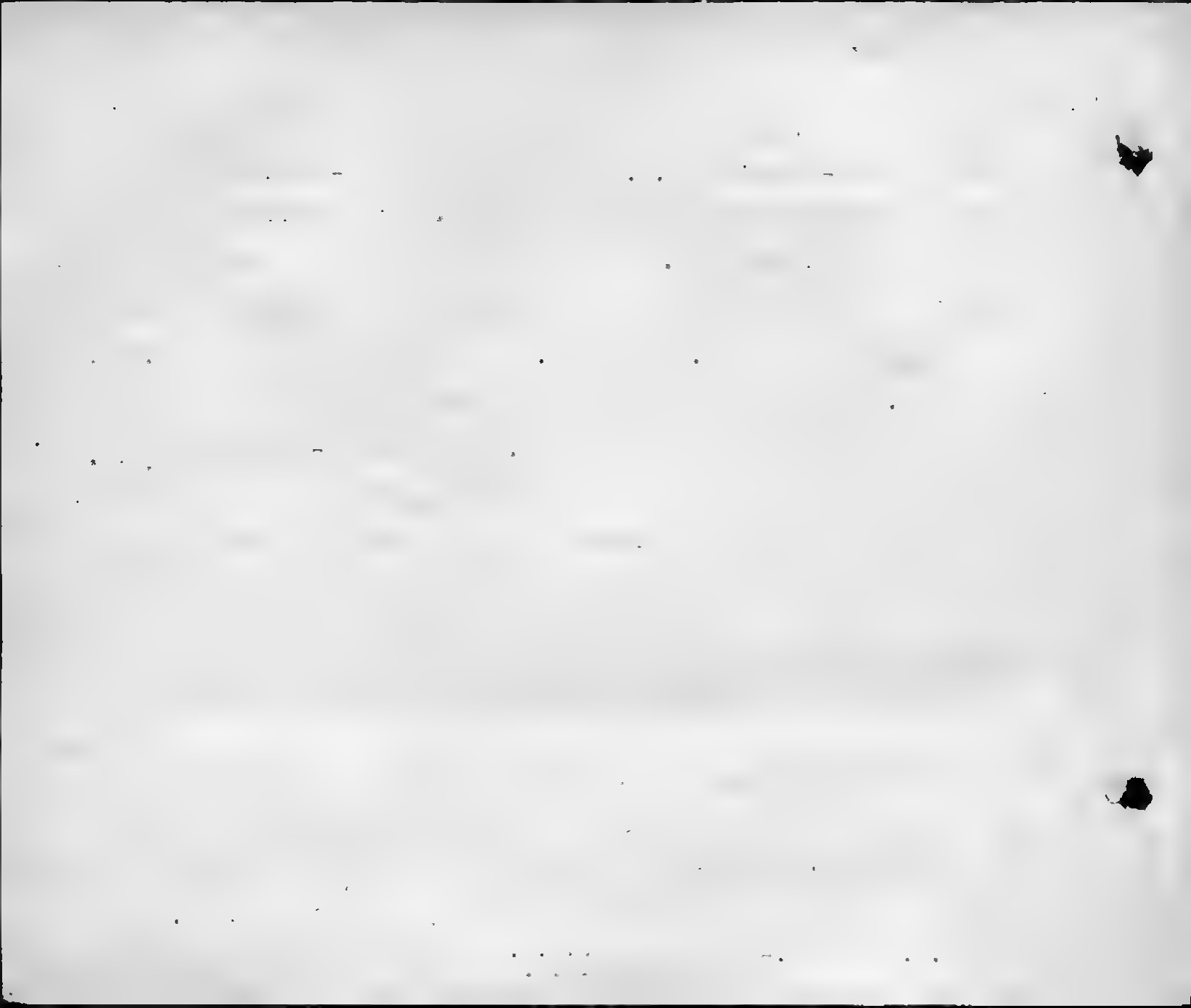
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4588

04576

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if last full one; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton City-Rockville P.O.</u>		c. LENGTH OF STAY IN 1b <u>Wheaton City -Rockville Post Office</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12722 Robindale Drive</u>		d. STREET ADDRESS <u>12722 Robindale Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Anderson</u> H. Middle <u>Tackett</u> Last <u>Tackett</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7/29/1881</u>	9. AGE (in years; if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) Months Days Hours Min. <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Trade Comm.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>
13. FATHER'S NAME <u>King S. Tackett</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Tackett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		17. INFORMANT <u>Mrs. Arthur Howard</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>diabetes mellitus</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 13, 1961</u> to <u>April 15, 1961</u> , that (I) <u>no</u> last saw the deceased alive on <u>April 12, 1961</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen C. Cromwell</u>		22b. DATE SIGNED <u>4/15/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>		22d. ADDRESS <u>615 W. Montgomery Ave., Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/18/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hims Co.</u>		25a. REC'D BY REGISTRAR <u>APR 17 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

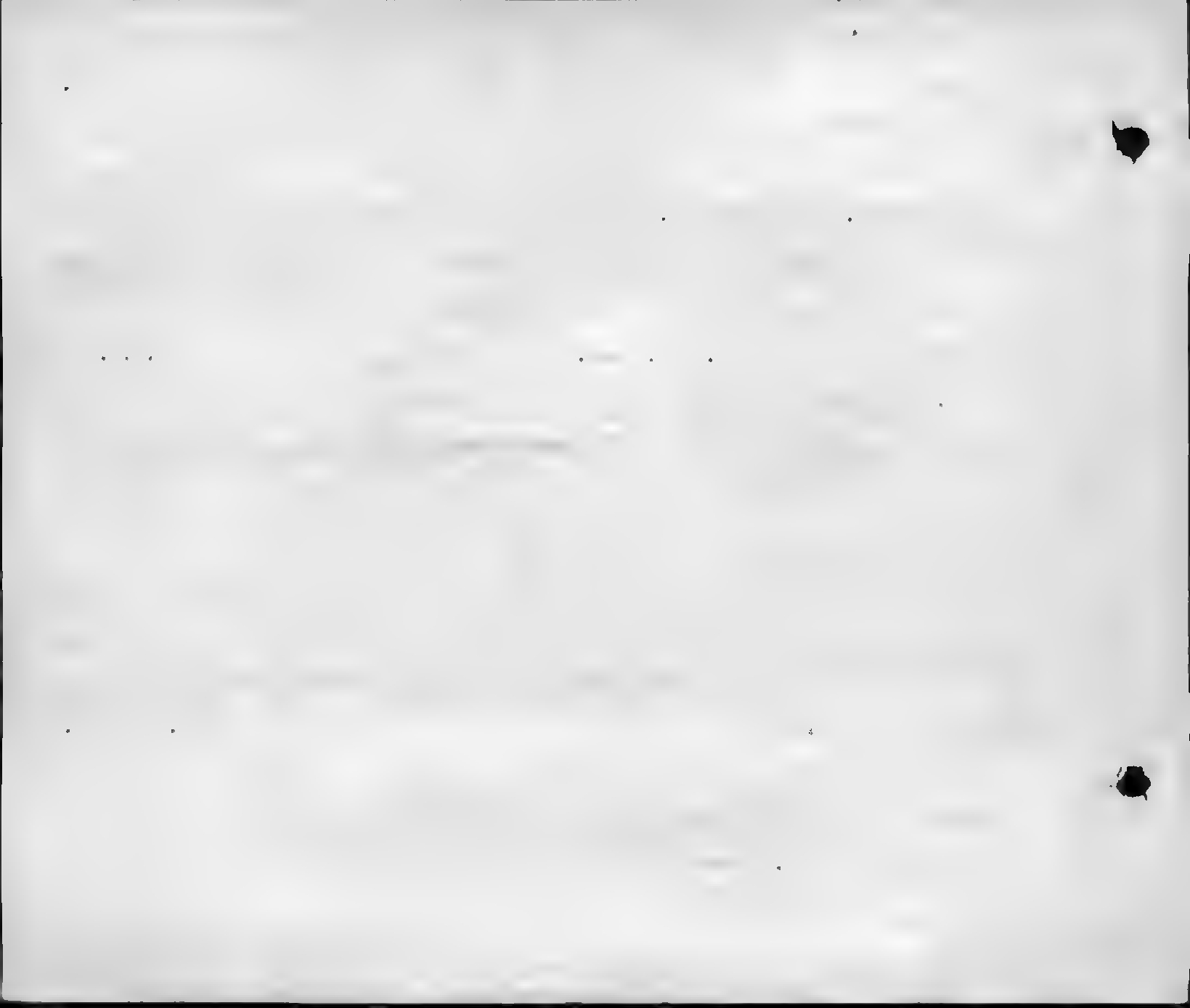
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if not full time; Residence before admission) a. STATE Maryland				b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bradley Blvd. & Arlington Rd.				d. STREET ADDRESS 114 Edenton Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Edward Tawes				4. DATE OF DEATH April 6 1961				5. SEX Male			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH 8/17/28			
9. AGE (In years last birthday) 32 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME W. Edward Tawes				14. MOTHER'S MAIDEN NAME Dorothy Revelle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 218-24-5044				17. INFORMANT Bar. 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Multiple Crushed injuries, extreme 112.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Caught behind bumper of crane and retaining wall			
20a. TIME OF INJURY Month Day, Year Hour 3:55 4/6/61 p.m.				20b. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>				20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street			
20d. (City or town) Bethesda				20e. (County) Mont.				20f. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BIRTHAL, CREMATION, or OTHER (Specify) Burial				22b. DATE THEREOF 4/9/61				22c. NAME OF CEMETERY OR CREMATORY Sumner-Johnson			
22d. LOCATION (City, town, or country) Bethesda				22e. (State) Md.				22f. (Country) U.S.A.			
23. FUNERAL DIRECTOR Bradshaw & Son				24a. REC'D BY REGISTRAR APR 13 1961				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

(M)

(I)

(2)

(1)



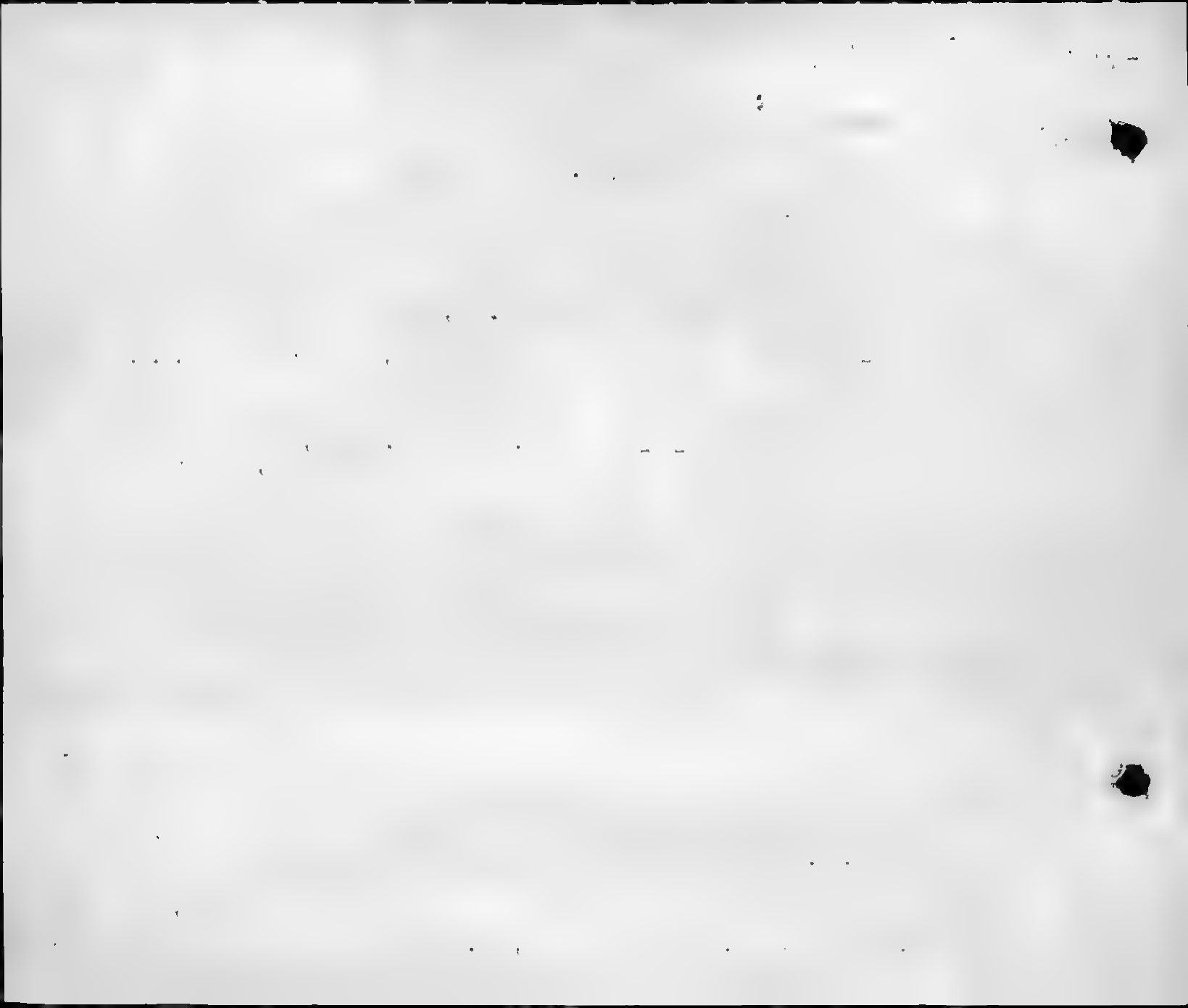
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE c. LENGTH OF STAY IN b. 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1310 VIERS MILL ROAD		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before death, if on) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 1310 VIERS MILL ROAD e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) JAMES (Demetrios) THOMAS		4. DATE OF DEATH APRIL 26 19 61	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1886	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Assenograd, Bulgaria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 357-07-5844	
17. INFORMANT Mrs. Timothy B. Riley, 1310 Viers Mill Road Rockville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c) 10-15 min PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15-20 yrs.		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 11-23 , 19 57 , to 4-26 , 19 61 , that (I) (the) last saw the deceased alive on 3-18 , 19 61 , and that death occurred 2:27 PM, from the causes and on the date stated above.			
22a. SIGNATURE W. G. Hall		22b. PHYSICIAN'S NAME (Type) W. G. HALL	
22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 615 W. MONTGOMERY AVE ROCKVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/28/61	
23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC.		25a. REC'D BY REGISTRAR MAY 1 '61	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

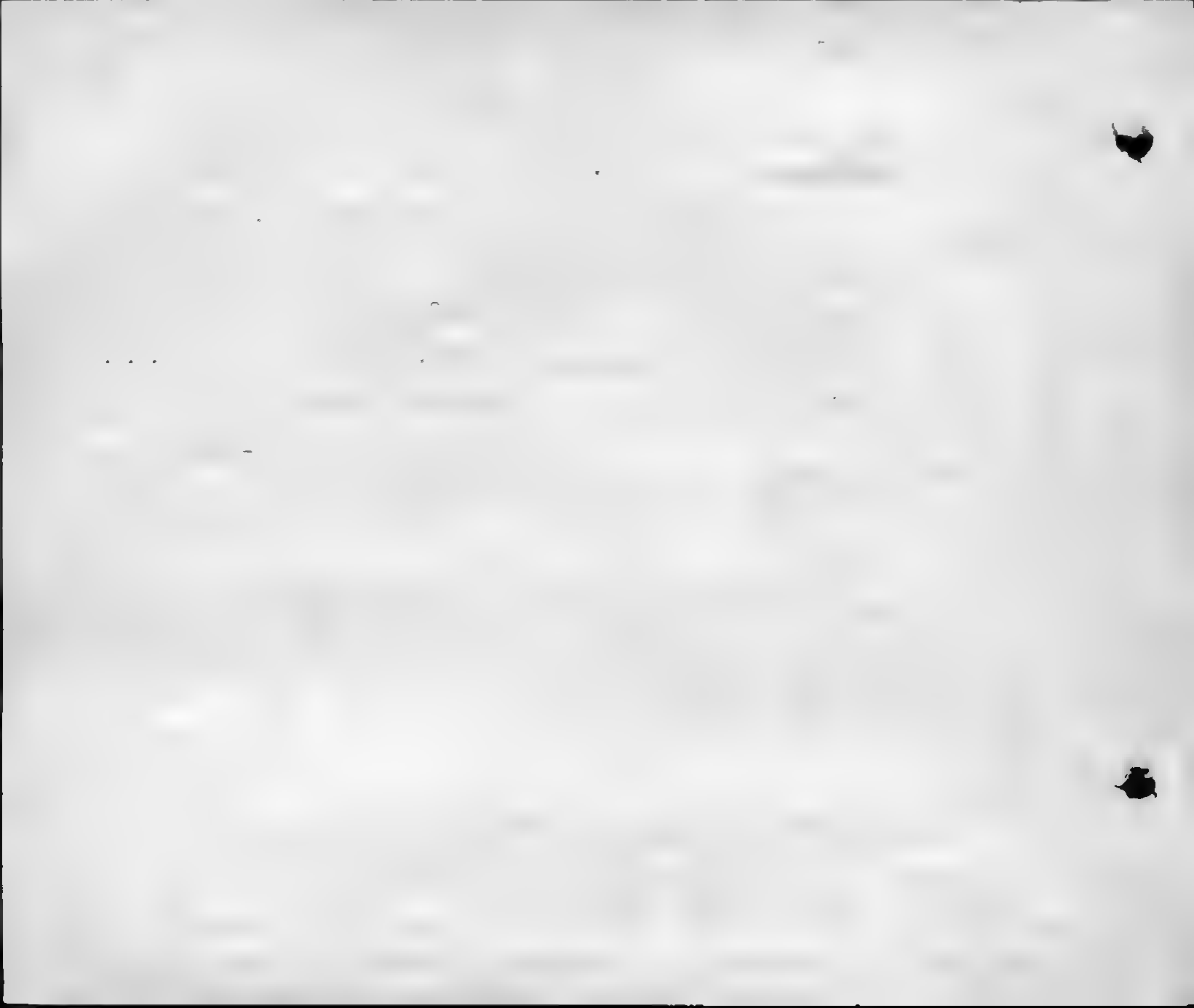
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0588

04572

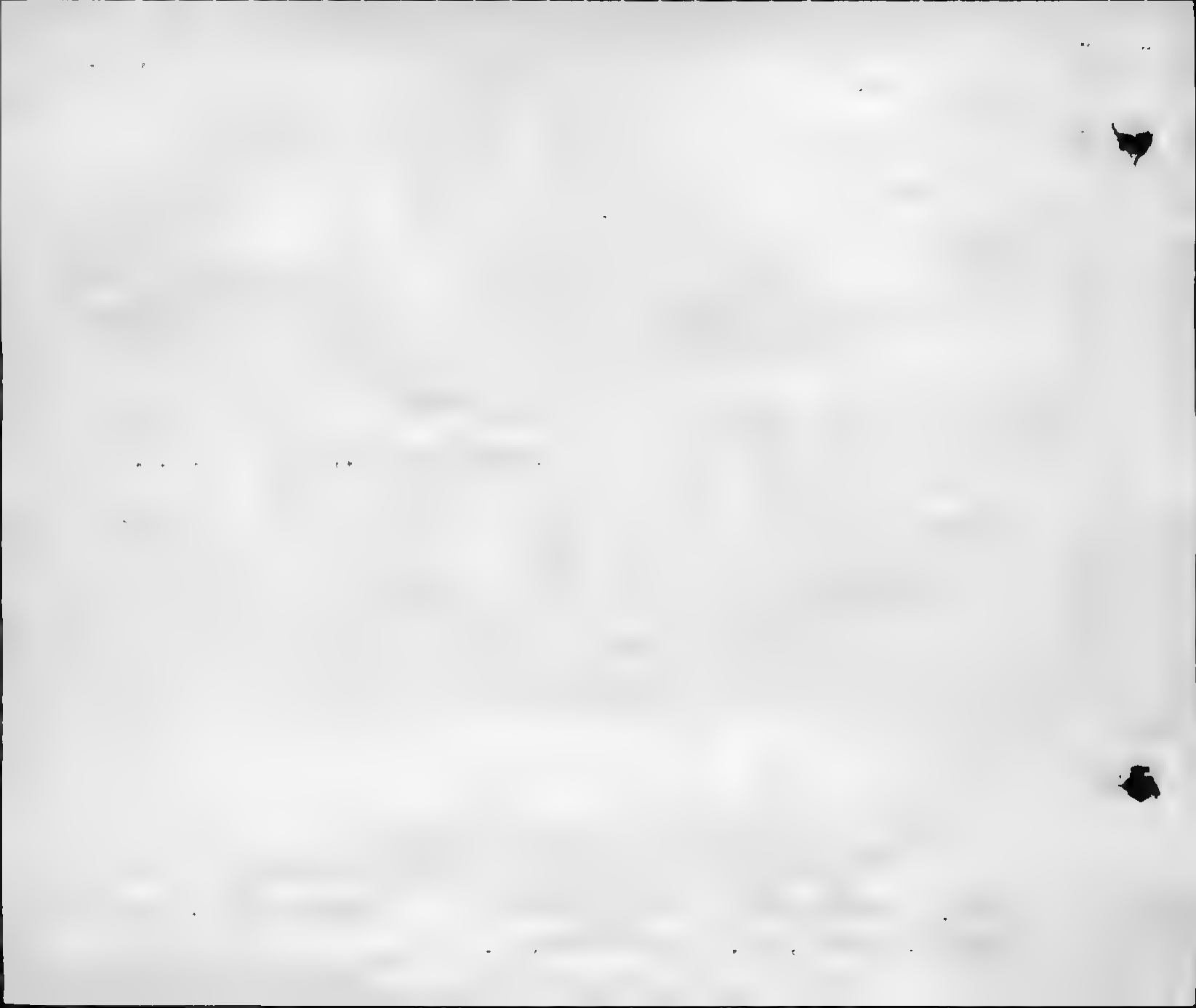
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>13 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Ann's Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6007 Johnson Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>HELEN AZMEKIAN TURMANIAN</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Malatia, Armenia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hovanes Tutelian</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kevorkian</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Armenie Turmanian (daughter-in-law)</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION AND MYOCARDIAL INFARCTION</u> DUE TO <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertension</u> DUE TO <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7-12</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> <u>1961</u> to <u>4/18</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>4/17</u> <u>1961</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u> </u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>april 21, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d. LOCATION (City, town or county) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u> </u>		DATE <u>APR 21 '61</u>	

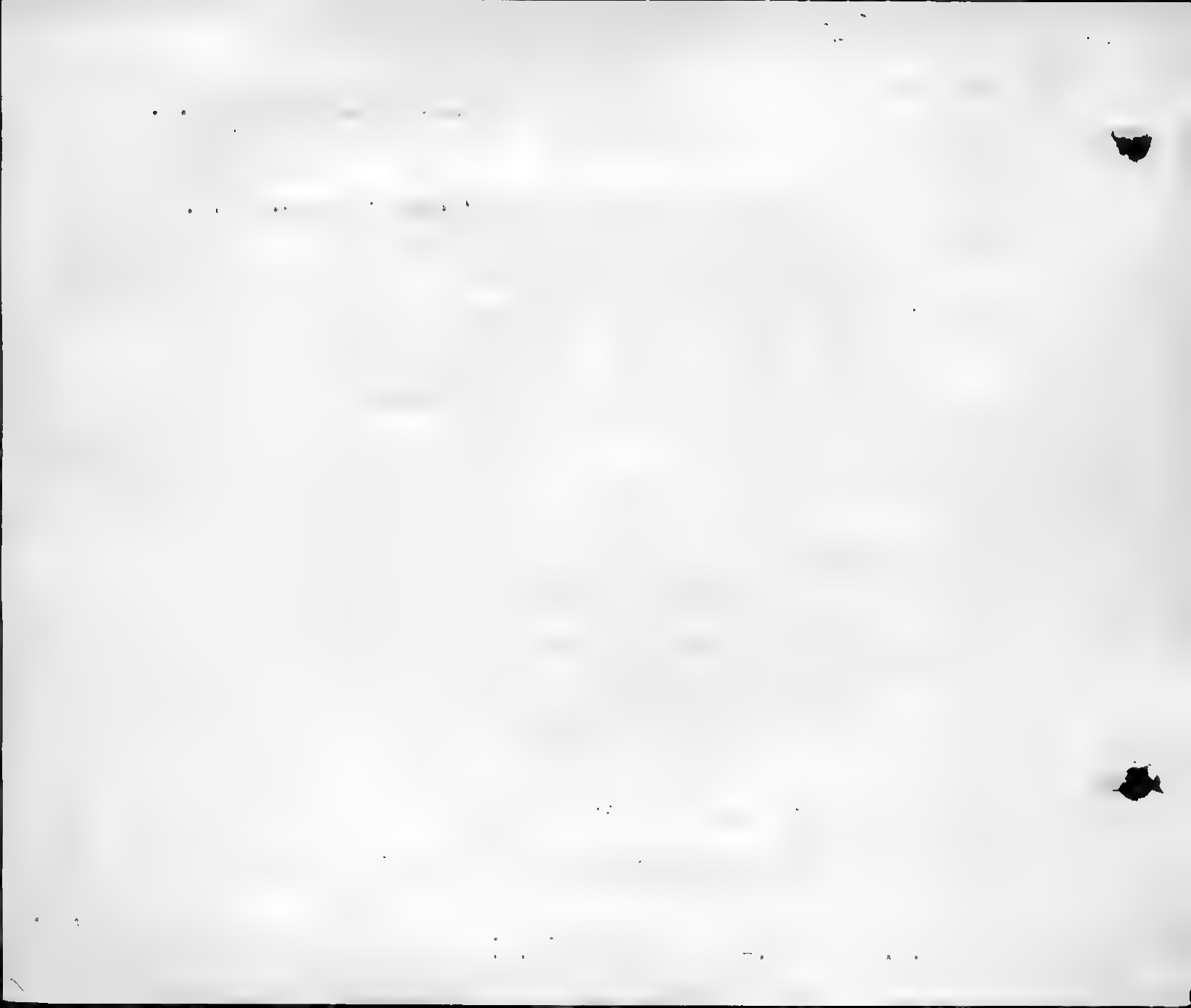


TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>6 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sentinels & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if not last residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>362 Deane Avenue</u>					
3. NAME OF DECEASED (Type or print) <u>Mirna (NMA) Van Loof</u>		4. DATE OF DEATH April 6 1961		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-21-76 85 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months Days	
13. FATHER'S NAME <u>William Morris</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Sgt. M. T. ...</u>		Address <u>5202 Carriage Dr., Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, AMED ATE CAUSE (a) <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) <u>ACUTE PULMONARY EDEMA</u> c) <u>CONGESTIVE HEART FAILURE</u> <u>GENERALIZED ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 mos.</u> <u>4-5 yrs</u>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 15, 1961</u> to <u>APRIL 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>APRIL 6, 1961</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>David ...</u>						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID ...</u>						22d. ADDRESS <u>1352 UNIVERSITY LANE</u>					
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) TRANS. & BURIAL 4/10/61						23c. NAME OF CEMETERY OR CREMATORY <u>HAMILTON CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MONMOUTH COUNTY, NEW JERSEY</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. ...</u>						ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>APR 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	





4592

CERTIFICATE OF DEATH

Reg. Dist. No. 04562

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN TB <u>63 yrs</u>		d. STREET ADDRESS <u>314 E Montgomery Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irene Victoria Agatha Viet</u>		4. DATE OF DEATH <u>April 19 1961</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22, 1877</u>
9. AGE (In years last birthday) <u>83 yrs</u>		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry van der von Oomkens</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Frye</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>INFORMANT</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary Occlusion</u> Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Ruptured atheromatous plaque</u> (b) <u>4-5 days</u> (c) <u>4-5 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>4-5 days</u> <u>4-5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1956</u> to <u>April 19 1961</u> , that I last saw the deceased alive on <u>April 19 1961</u> and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Corinne Cooper</u> M.D.		ADDRESS (Street, city or town, state) <u>104 S Washington St Rockville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>4/22/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		24a. REC'D BY REGISTRAR <u>APR 24 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR A. DING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after, th. Page 4
may be retained by: hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4745

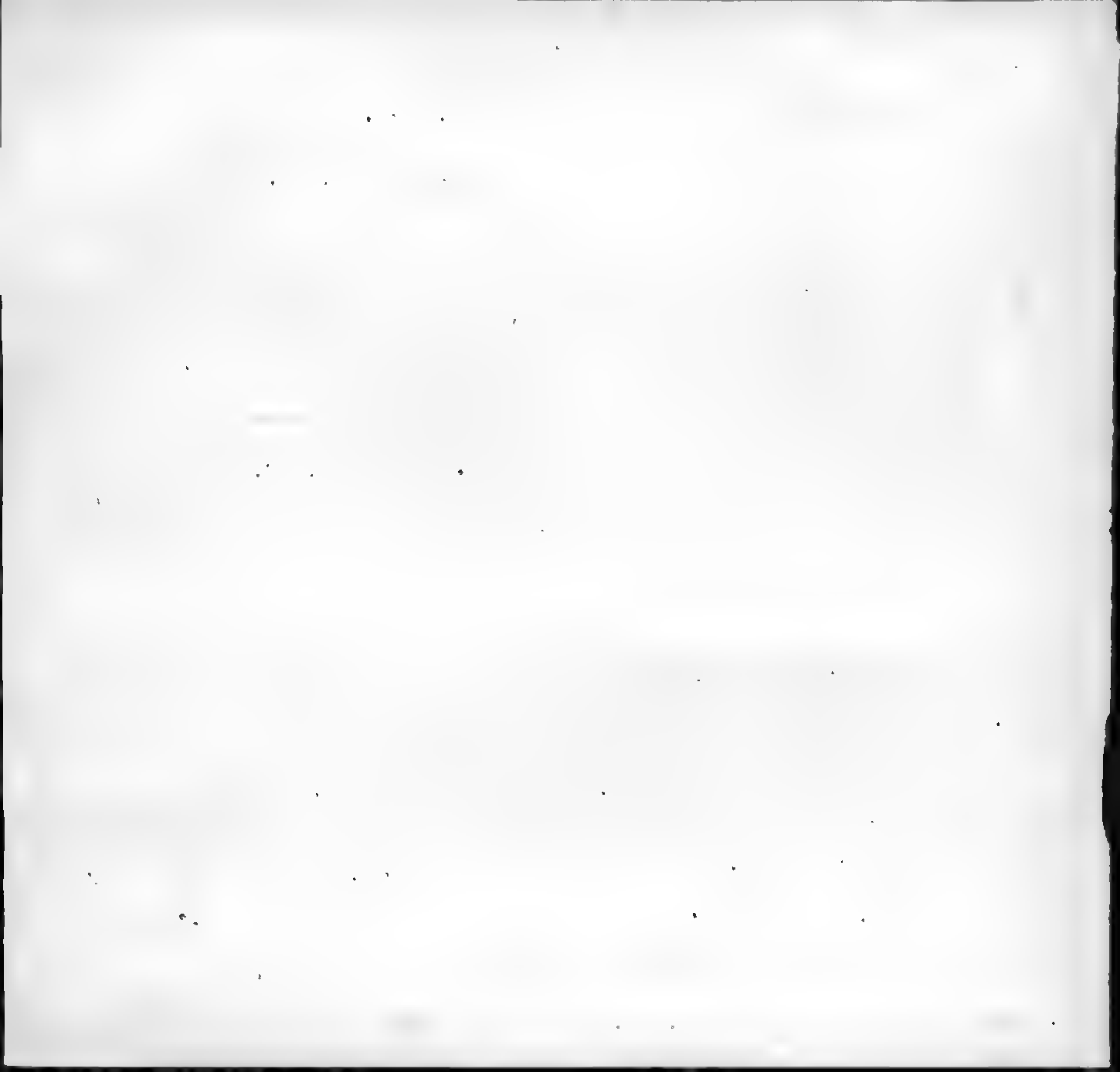
Item 1 Film G305 1/9/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 04732

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nursing Home</u>		d. STREET ADDRESS <u>Mitchellsville, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Johnsons</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LUDWIG</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>white male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 2, 1882</u>	
9. AGE (In years lost birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ludwig Voll</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Alfred J Heine</u>		Address <u>Bowie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 15, 1961</u> to <u>April 21, 1961</u> , that I last saw the deceased alive on <u>April 20, 1961</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>A. F. Thibadeau</u>		DATE SIGNED <u>4/21/61</u>	
PHYSICIAN'S NAME (Type) <u>A. F. THIBADEAU</u>		ADDRESS (Street, city or town, state) <u>10111 Columbia Rd. Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4593

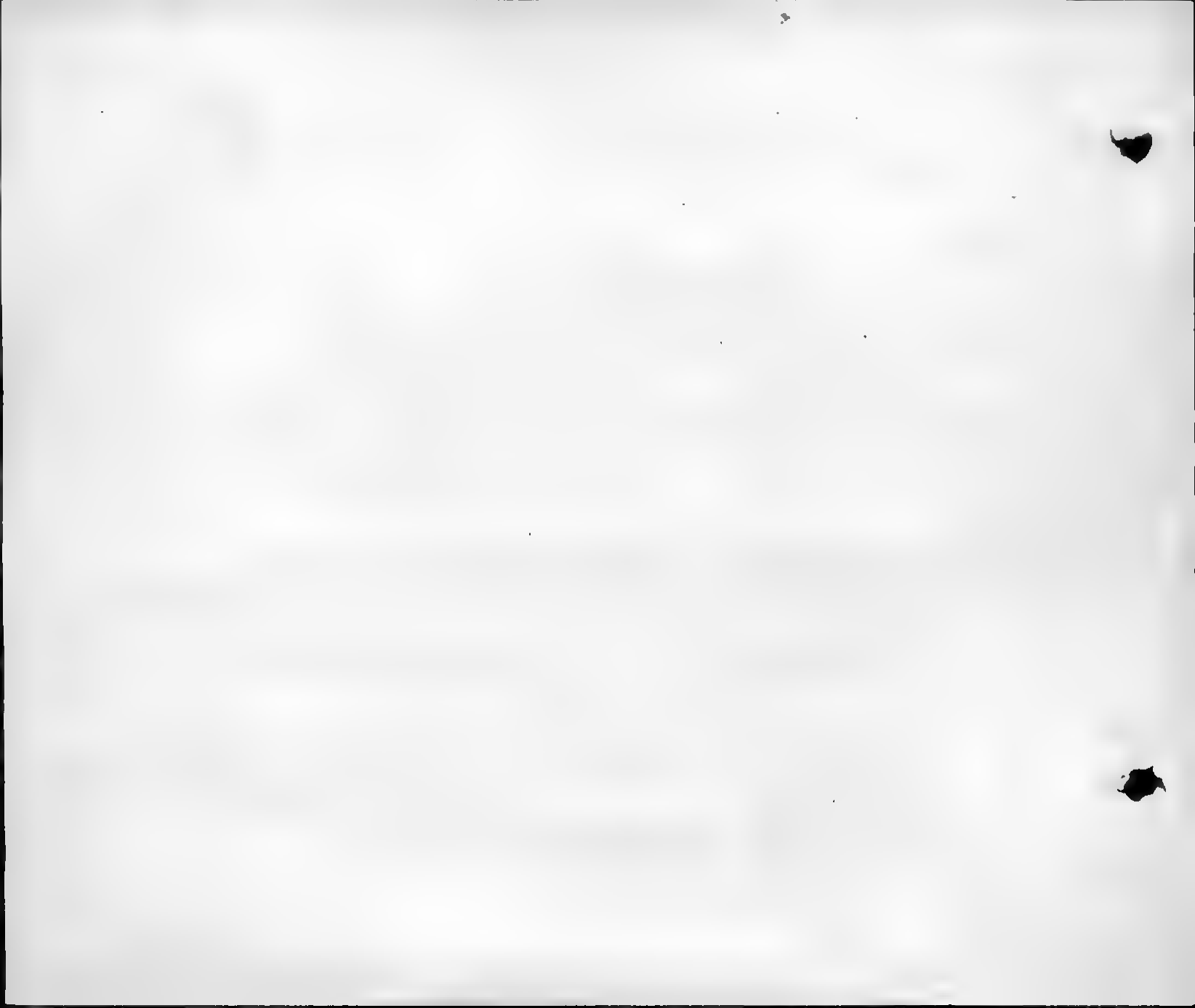
04583

1. PLACE OF DEATH o COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Md.</u> b COUNTY <u>MONTG</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c LENGTH OF STAY IN 1b <u>YEARS</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7307 BALTIMORE AVE.</u>				d STREET ADDRESS <u>7307 BALTIMORE AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DONALD D. WALLACE</u>				4. DATE OF DEATH Month Day Year <u>APRIL 5, 1961</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1908</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insulator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insulating</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Donald M. Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Sorbus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mr. Neomi E. Wallace (same as #2)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extensive Cerebral Strophy</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>5 Apr.</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4 Apr.</u> 19 <u>61</u> , and that death occurred at <u>7:18</u> A. M. from the causes and on the date stated above							
22a. SIGNATURE <u>M. B. Queen</u> M. D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>5 Apr 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN M.D.</u>				22d. ADDRESS <u>7112 Willow Ave TAKOMA PARK, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 7, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Martin</u> ADDRESS <u>254 Carroll St NW D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

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X

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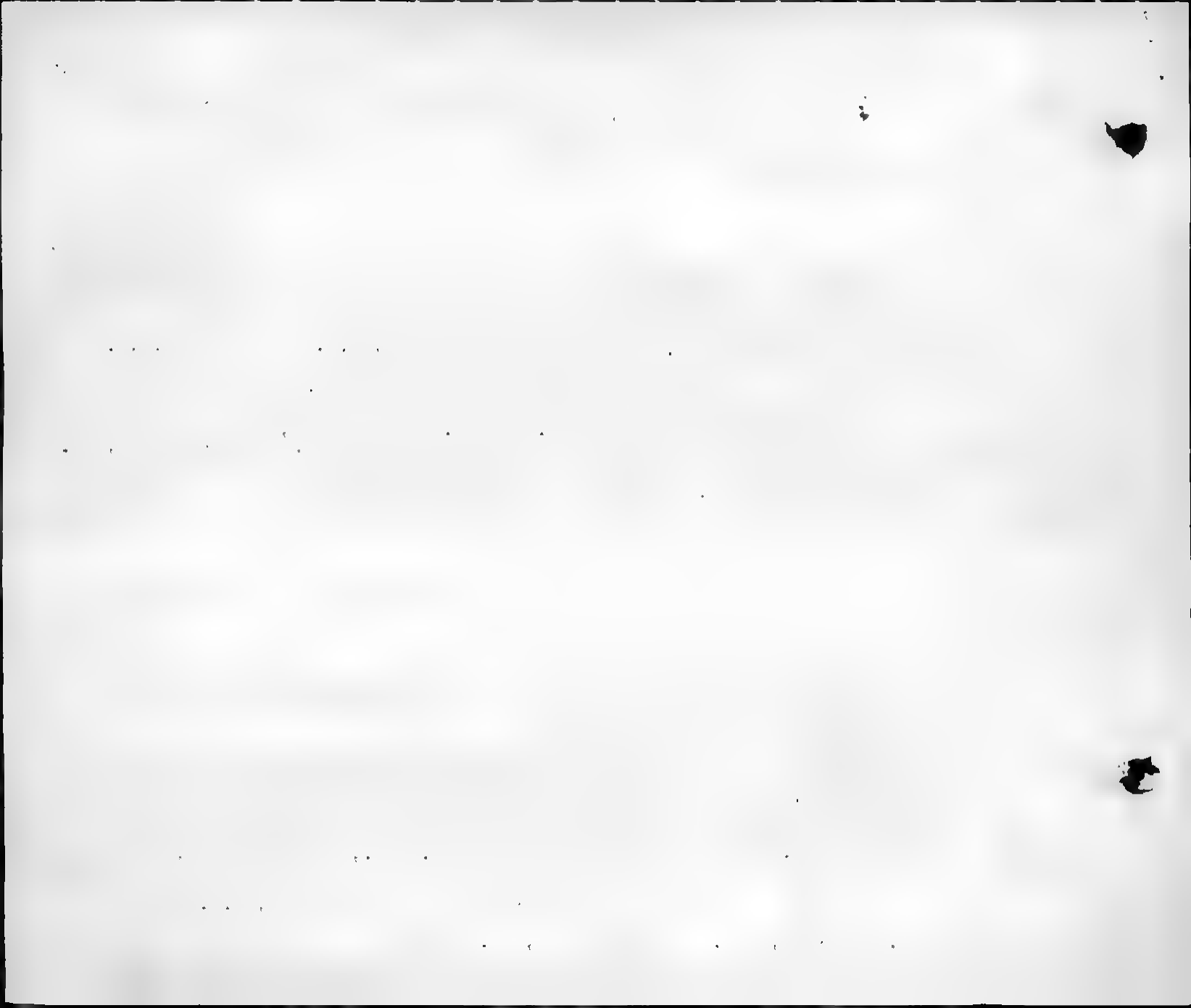
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

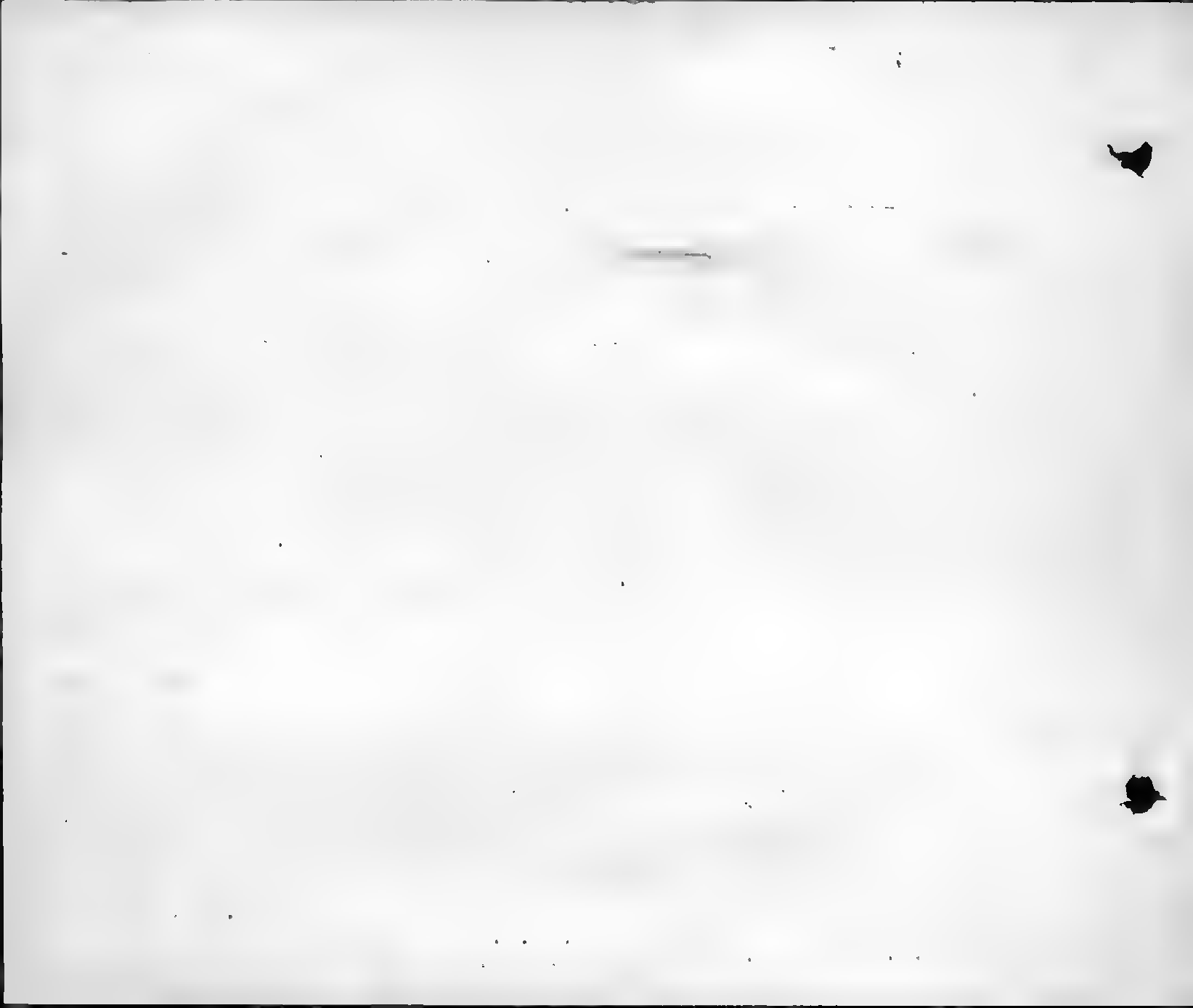
4594

04584

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 14 years		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 809 GIST AVENUE				d. STREET ADDRESS 809 GIST AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle WALTER Last WALLINGSFORD				4. DATE OF DEATH Month APRIL Day 16 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/22/72	9. AGE (In years last birthday) 88 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRIDGE CONSTRUCTION		10b. KIND OF BUSINESS OR INDUSTRY PENN. RAILROAD		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM WALLINGSFORD				14. MOTHER'S MAIDEN NAME ELLA ROSE unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Ruth P. Wallingsford, wife 809 Gist Ave., Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 10, 1958 to April 16, 1961 , that (I) (we) last saw the deceased alive on April 12, 1961 , and that death occurred at 5:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE Aaron H. Traum				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 17, 1961	
22c. PHYSICIAN'S NAME (Type) AARON H. TRAUM				22d. ADDRESS 8237 GA. AVE., SILVER SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/18/61		23c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond A. Ziska				25a. REC'D BY REGISTRAR DATE APR 19 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION





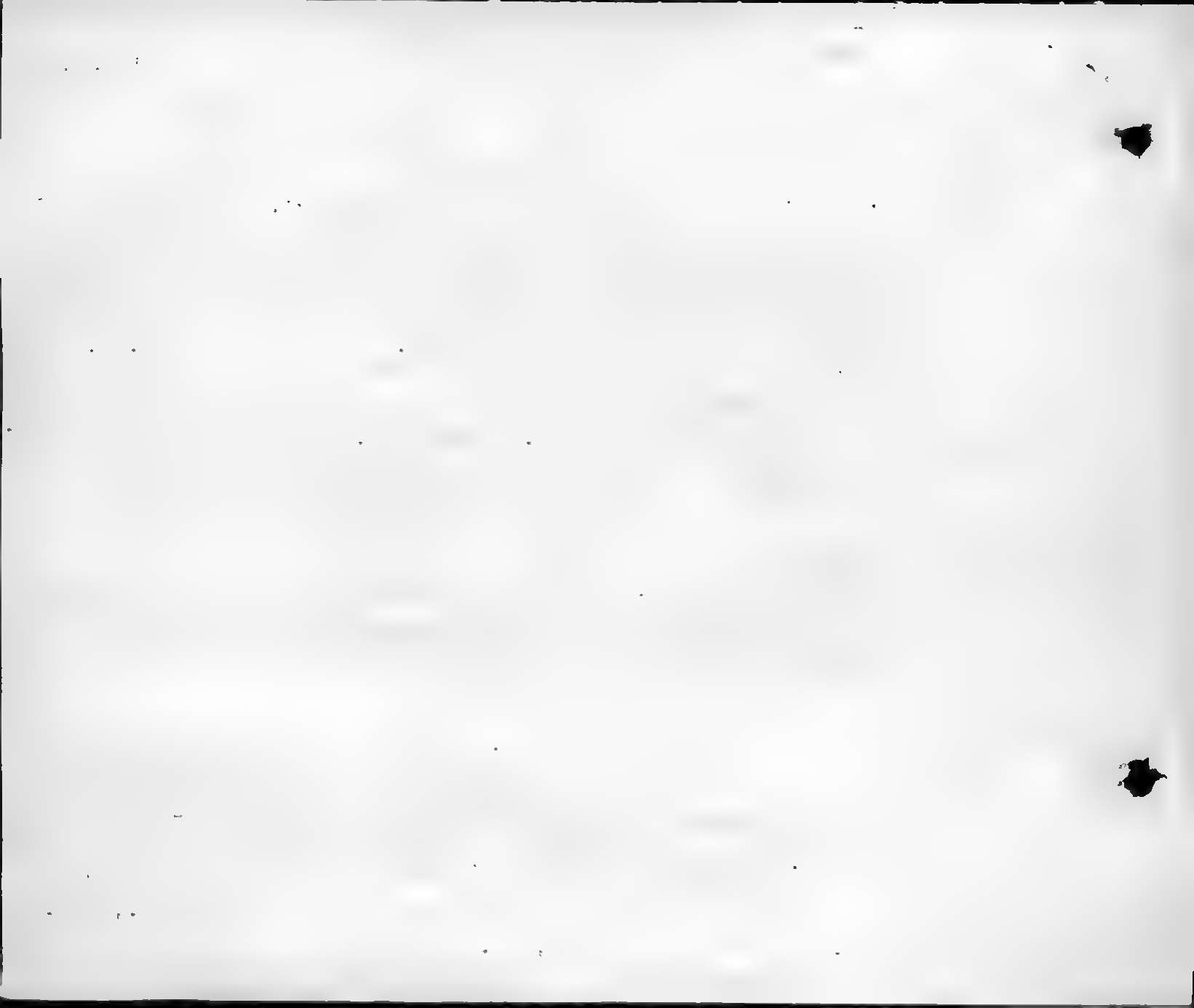
Page 4 of 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4596

04586

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrett Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Kensington Gardens Sanitarium</i>		d. STREET ADDRESS <i>11016 Rokeby Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>BESSIE Bower WEBB</i>		4. DATE OF DEATH <i>APRIL 15 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>23 Feb. 1888</i>
9. AGE (In years last birthday) <i>73</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>William H. Bower</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Rich.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes Unknown</i>	
17. INFORMANT <i>Mrs. Elizabeth W. Crichton</i>		Address: <i>Same as Item 2.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis. Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March 1958</i> , to <i>April 15 1961</i> , that (I) two last saw the deceased alive on <i>April 15 1961</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above			
22a. SIGNATURE <i>Seruch T. Kimble</i>		22b. DATE SIGNED <i>4-16-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i>		22d. ADDRESS <i>929 Prashing Drive Silver Spring Md.</i>	
23a. BLR AL CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>4-17-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town, or county) (State) <i>Prince George Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		25a. REC'D BY REGISTRAR <i>Bethesda, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>Apr 19 '61</i>		25c. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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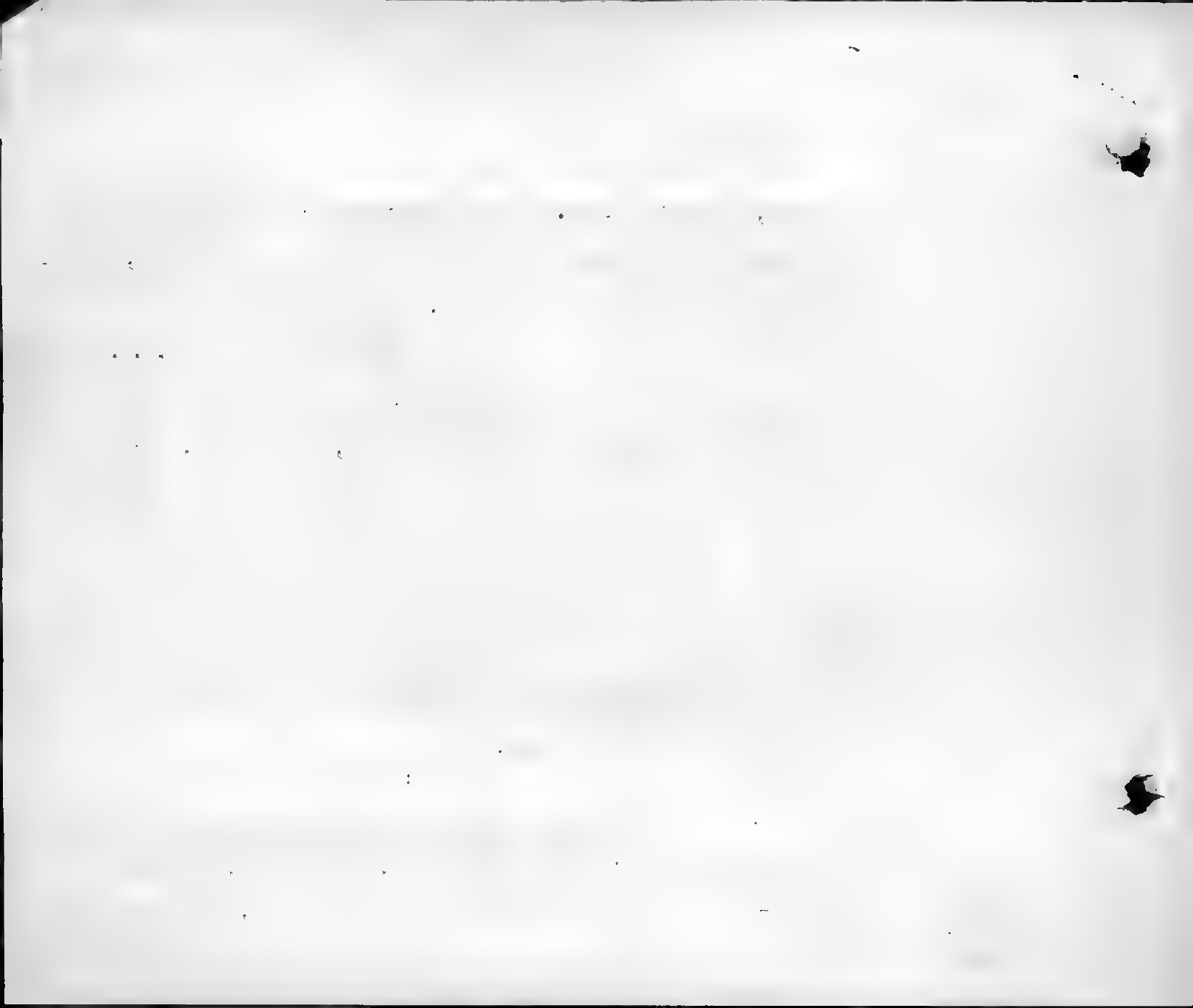
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4597

04587

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 42 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida		b. COUNTY 48Y	
d. NAME OF HOSPITAL (If not in hospital, give street address; OR INSTITUTION) The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 1305 Crestview Street				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hannah		Middle Haines		Last Webb		4. DATE OF DEATH Month April		Day 2,	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12, 1889		9. AGE (In years last birthday) 71 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alanson Haines				14. MOTHER'S MAIDEN NAME Clara Wiswill					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Neoplasm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 9 Months DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 9 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Newfields, New Hampshire		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 19, 1961 to April 2, 1961 that (I) (we) last saw the deceased alive on April 2, 1961 and that death occurred at 9:15 PM from the causes and on the date stated above									
22a. SIGNATURE Michael W. Brandriss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-3-61			
22c. PHYSICIAN'S NAME (Type) MICHAEL W. BRANDRIS, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 4-3-61		23b. DATE THEREOF 4-3-61		23c. NAME OF CEMETERY OR CREMATORY Newfields Cemetery		23d. LOCATION (City, town, or county) (State) Newfields, New Hampshire			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 6 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kram	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

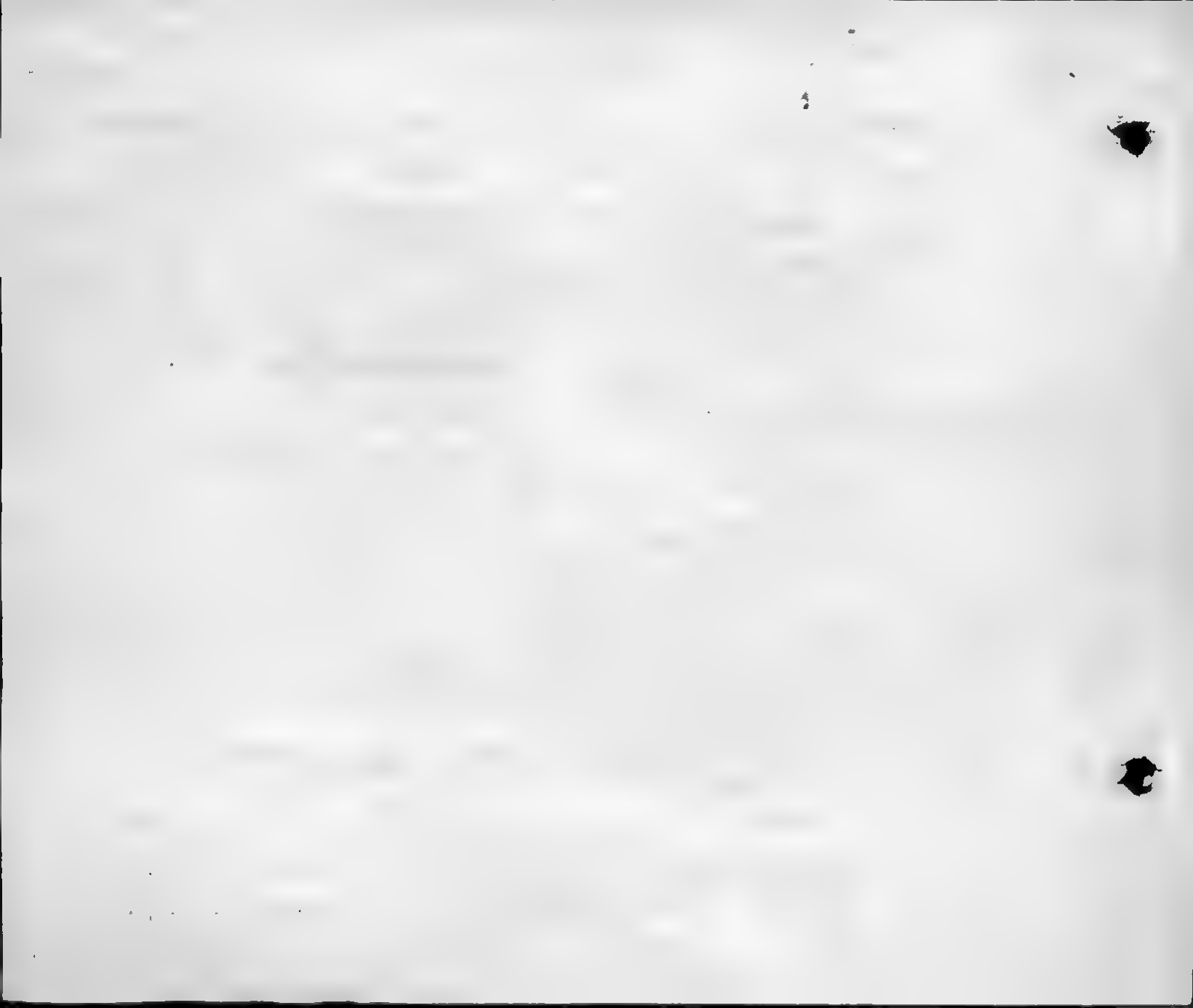
CERTIFICATE OF DEATH

4598

04568

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7805 Overhill Road</u>			
3. NAME OF DECEASED (Type or print) <u>Frances Adele Wenger</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1961</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 15, 1873</u>			
9. AGE (in years last birthday) <u>88</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hwf.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Louis A. Roussel</u>			
14. MOTHER'S MAIDEN NAME <u>Amelie Corney</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Ruth Wenger Dawson (Daughter)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> (b) <u>Congestive Failure</u> (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>18 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>None</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1961</u> to <u>April 6, 1961</u> that (I) (we) last saw the deceased alive on <u>April 6, 1961</u> and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>William H. Killay</u>		22b. DATE SIGNED <u>4/6/61</u>		22c. PHYSICIAN'S NAME (Type) <u>William H. Killay</u>			
22d. ADDRESS <u>5218 Wisconsin Ave</u>		23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>4/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>APR 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Robert S. Frank</u>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

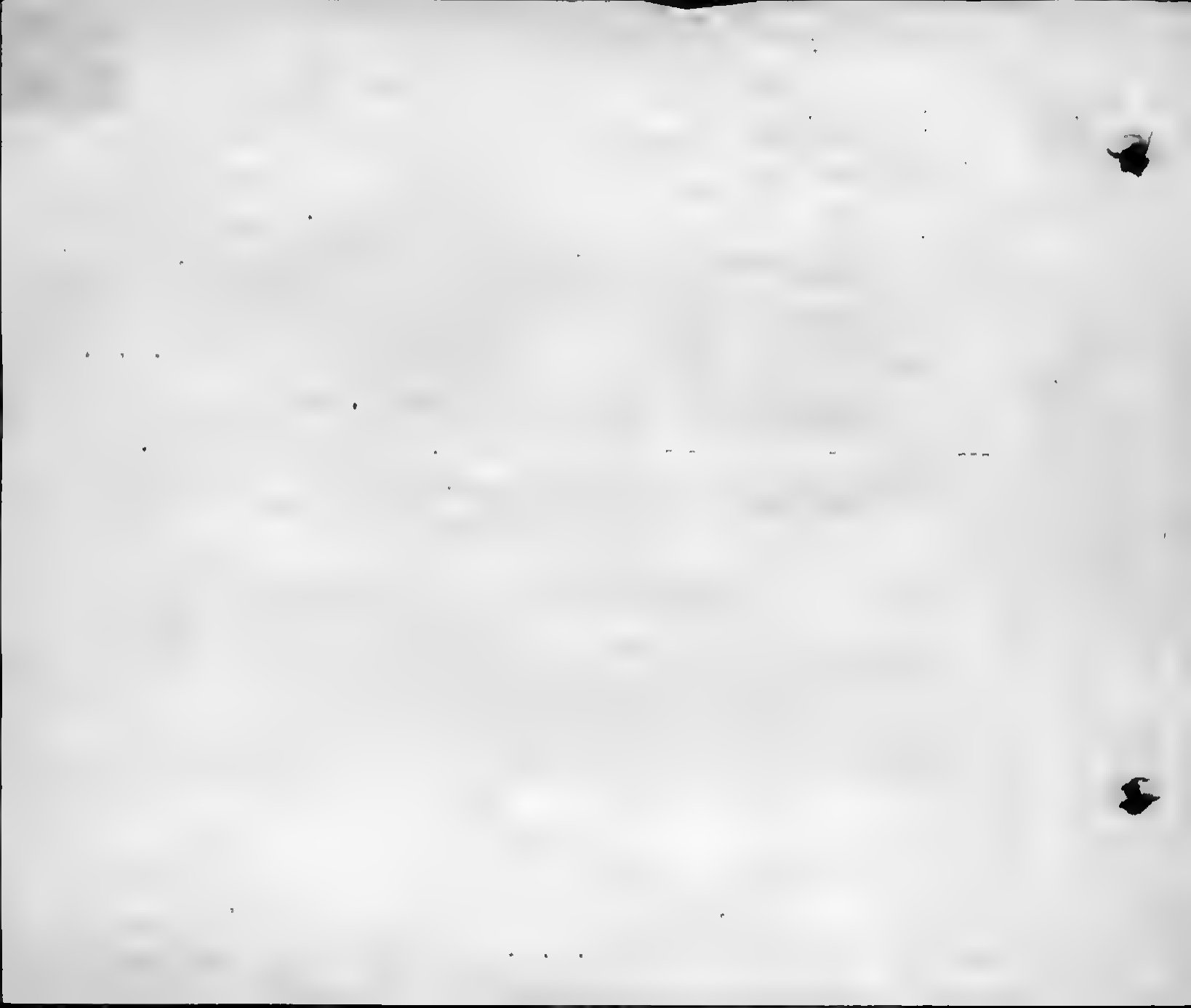
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

04560

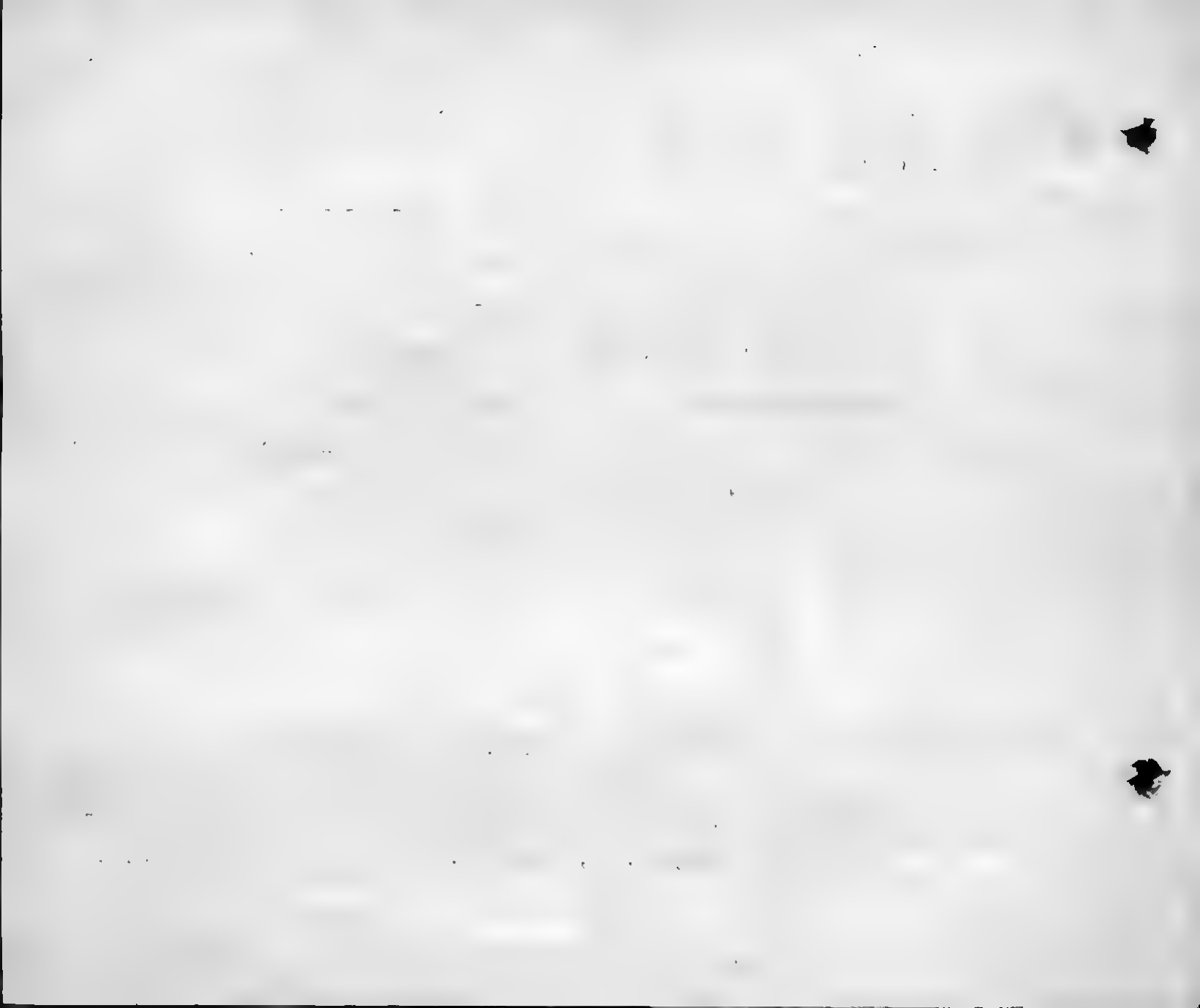
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 10202 Menlo Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10202 Menlo Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gertrude May Whipple				4. DATE OF DEATH Month April , Day 16 , Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July ? 1873	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87 Days 87		IF UNDER 24 HRS. Hours 87 Min. 87			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (Country & State, or foreign country) New York State	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Rufus Wood				14. MOTHER'S MAIDEN NAME Elizabeth D. Burton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---				16. SOCIAL SECURITY NO ---			
17. INFORMANT Calvin E. Whipple				Address 10202 Menlo Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/27 19 61 to 4/16 19 61 , that (I) (we) last saw the deceased alive on 4/14 19 61 , and that death occurred at 11/16 M, from the causes and on the date stated above.							
22a. SIGNATURE William D. And MD				22b. DATE SIGNED 4/17/61		22c. PHYSICIAN'S NAME (Type) WILLIAM D. AND	
22d. ADDRESS 906 Culmville Rd Silver Spring Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF April 20, 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 Georgia Ave. N. W.		25a. REC'D BY REGISTRAR DATE APR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris							



04590

4600

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

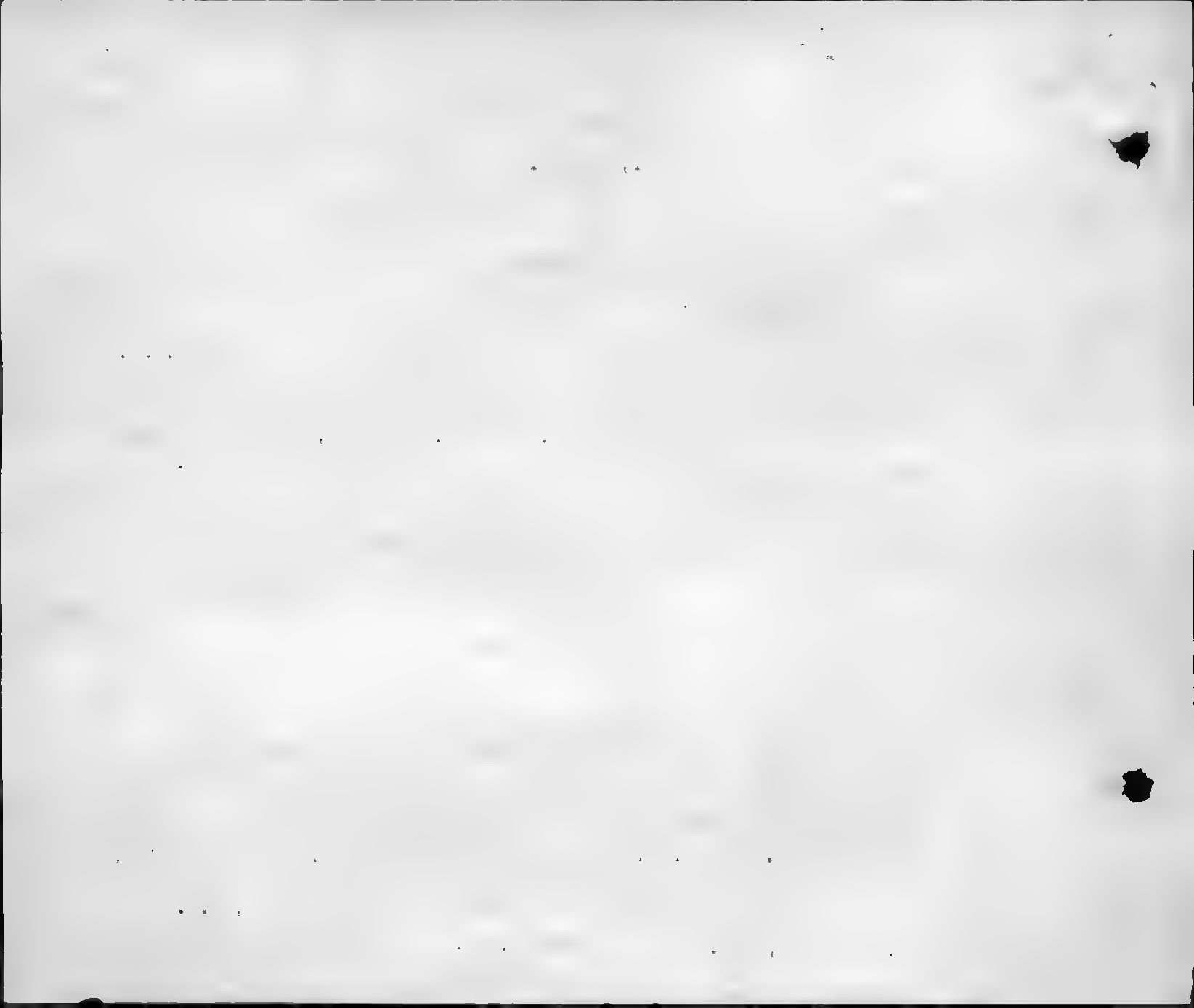
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04591

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 1 yr., 11 mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EVENTIDE NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, if institutions' Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 1903 PERSHING DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle MINERVA Last WILLIAMS		4. DATE OF DEATH Month APRIL Day 24 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		11. BIRTHPLACE (County & State, or foreign country) KANSAS	
13. FATHER'S NAME JAMES BOYD		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Frank H. Williams, 703 McNeill Road Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X uremia DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Arteriosclerotic heart disease			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 24, 1961 to April 24, 1961 , that (I) (we) last saw the deceased alive on April 24, 1961 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Seruch T. Kimble, M.D.		22b. DATE SIGNED 25 Apr '61	
22c. PHYSICIAN'S NAME (Type) Seruch T. Kimble, M.D.		22d. ADDRESS 927 Pershing Dr. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/27/61	23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY	23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pimpfrey, Inc.		25a. REC'D BY REGISTRAR APR 28 61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

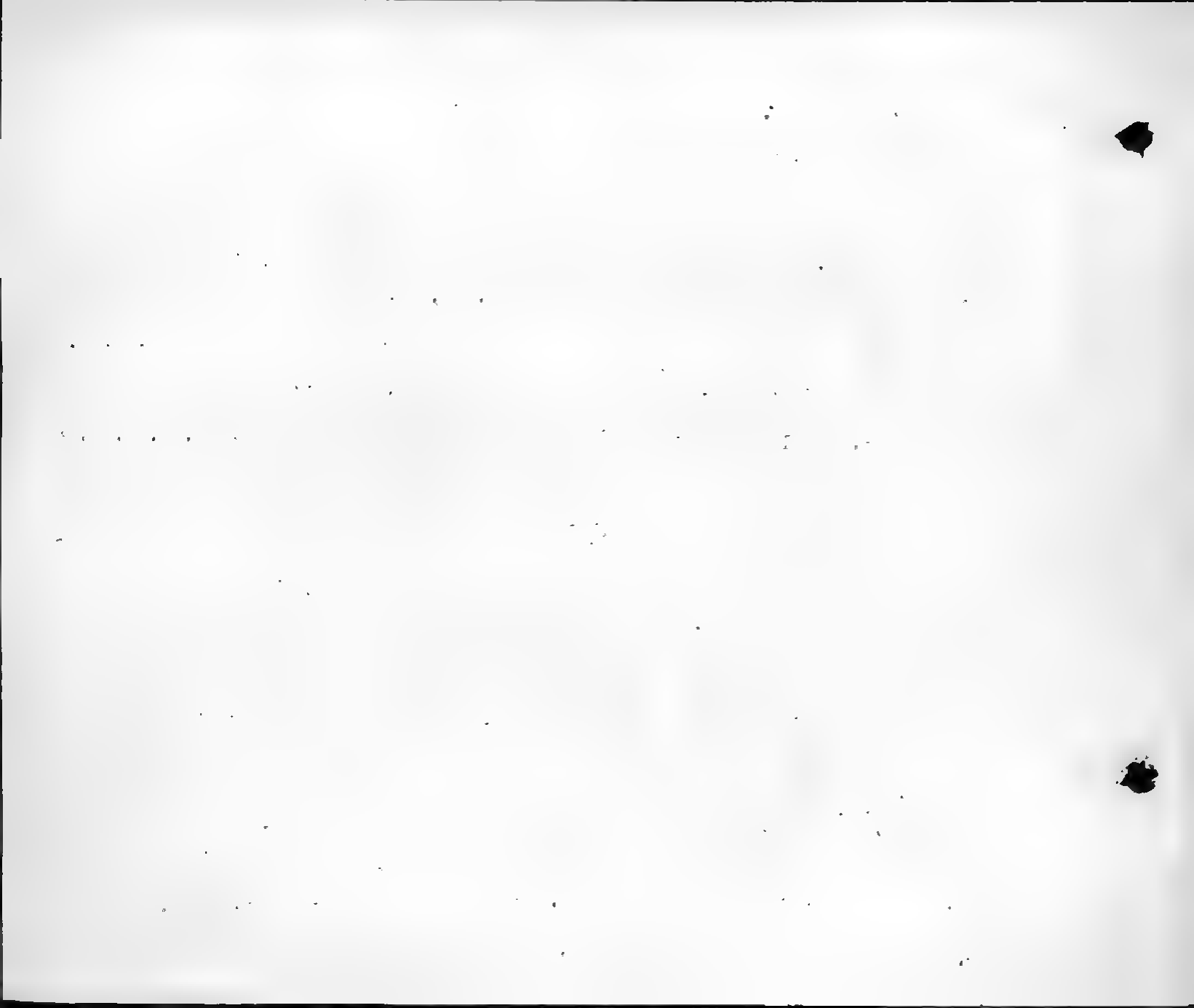


CERTIFICATE OF DEATH

Reg. Dist. No. 04592

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson (Rural) c. LENGTH OF STAY IN lb life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson (Rural) d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First MAURICE Middle MELVIN Last WILLIAMS		4. DATE OF DEATH Month April Day 15 Year 1961	
5. SEX male	6. COLOR OR RACE A. A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1888
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months 0 Days 15	IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Thomas J. Williams	
14. MOTHER'S MAIDEN NAME Nannie Betters		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	
16. SOCIAL SECURITY NO. 217-10-9885		INFORMANT Address Sadie Williams-- Dickerson, Md. R. F. D. 2	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Chronic glomerular nephritis			INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years 2 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hemiplegia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month June Day 19 Year 1958 Hour 0 a. m. 0 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 1958, to April 15 , 1961, that I last saw the deceased alive on April 6 , 1961, and that death occurred at 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Danville, Va. DATE SIGNED 4/15/61 ACTUAL SIGNATURE John L. Lawrence M.D. PHYSICIAN'S NAME (Type) JOHN LAWRENCE P.O. Box, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/18/61	22c. NAME OF CEMETERY OR CREMATORY Warren Chapel.	22d. LOCATION (City, town, or county) (State) Martinsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Lawrence		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE APR 20 '61
		24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4603

CERTIFICATE OF DEATH

04593

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph's Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1015 Spring St.</u>					
3. NAME OF DECEASED (Type or print) <u>William George Willert</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <u>4-28-1922</u>		9. AGE (In years last birthday) <u>38</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u></td> <td></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>									
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George Willert</u>					
14. MOTHER'S M.A.DEN NAME <u>Willie Ann Moore</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-32-9558</u>					
17. INFORMANT <u>Dr. H. George Hall</u>		18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>Uremia</u> (b) <u>Renal calculi</u> (c) <u>chronic pyelonephritis</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) (a) <u>100.0</u> DUE TO <u>Chronic pyelonephritis</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1015 Spring St., Silver Spring, Md.</u>					
20f. (City or town) <u>Silver Spring</u>		20g. (County) <u>Montgomery</u>		20h. (State) <u>Md.</u>					
21. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> to <u>4/11</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>4/11</u>, 19<u>61</u>, and that death occurred at <u>6:25</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Arthur J. Wilets</u>		22b. DATE <u>4/11/61</u>		22c. PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>4/13/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>High Hill Baptist Church Cemetery</u>					
23d. LOCATION (City, town or county) (State) <u>Jarratt, Sussex County, Va.</u>		24. ELIMINATOR'S SIGNATURE <u>Warner E. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>DATE APR 19 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur J. Wilets</u>		25c. ADDRESS <u>SILVER SPRING, MD.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



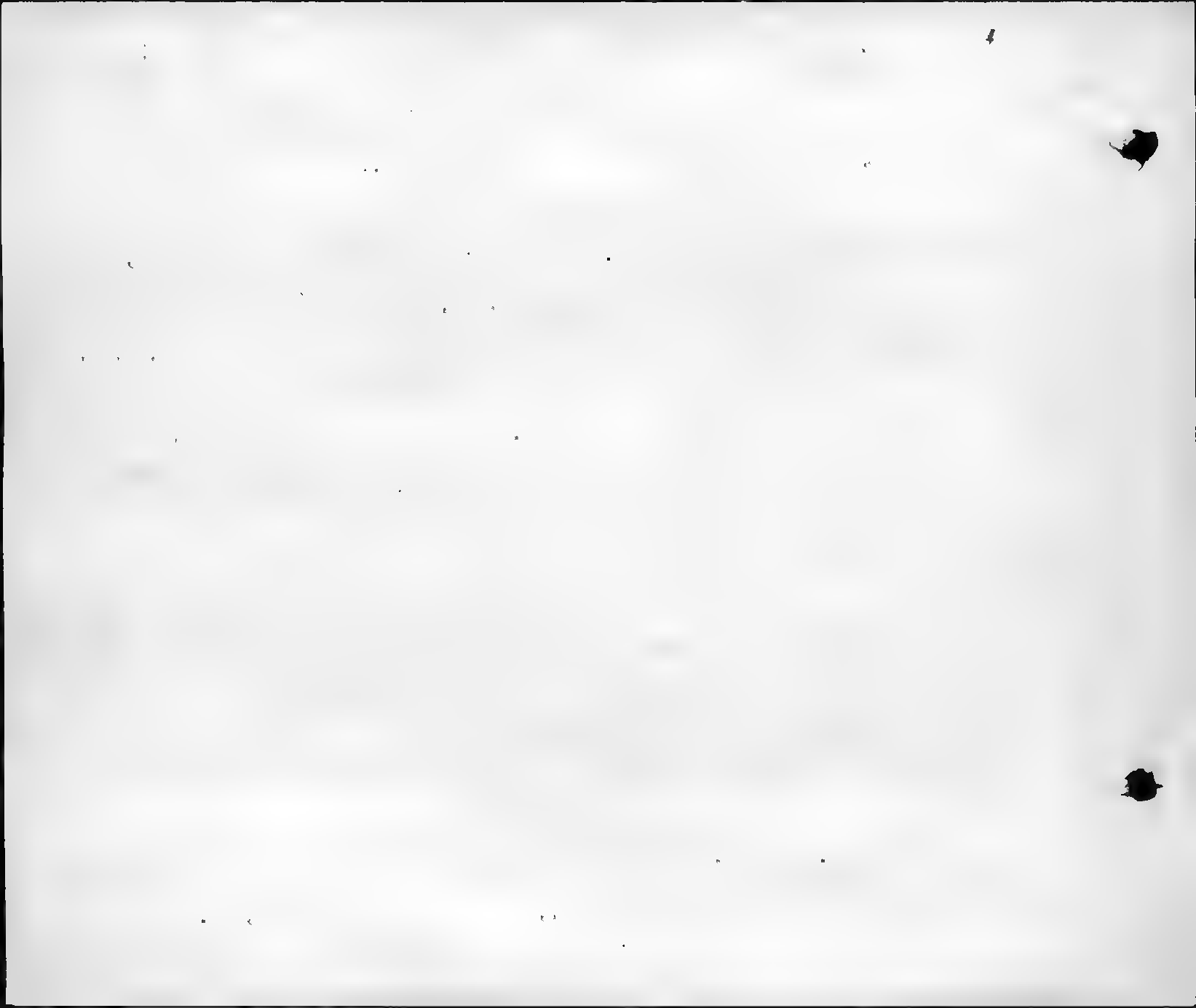
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4604
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04594

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>WIMS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 15, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.		10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Warner Wims</u>		14. MOTHER'S MAIDEN NAME <u>Marie E. Duffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give year or dates of service)</u>		17. INFORMANT <u>Mrs. Altia M. Wims.</u> Address <u>Clarksburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate with generalized metastases</u> DUE TO (b) <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> 19 <u>61</u> to <u>4/12</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>4/11</u> 19 <u>61</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James P. Kerr</u>		22b. PHYSICIAN'S NAME (Type) <u>Dr. James P. Kerr</u>		22c. ADDRESS <u>DAIMHSCUS, MD.</u>		22d. DATE <u>4/15/61</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill.</u>		23d. LOCATION (City, town, or county) (State) <u>Clarksburg, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Luzzadine</u>				25a. REC'D BY REGISTRAR DATE <u>APR 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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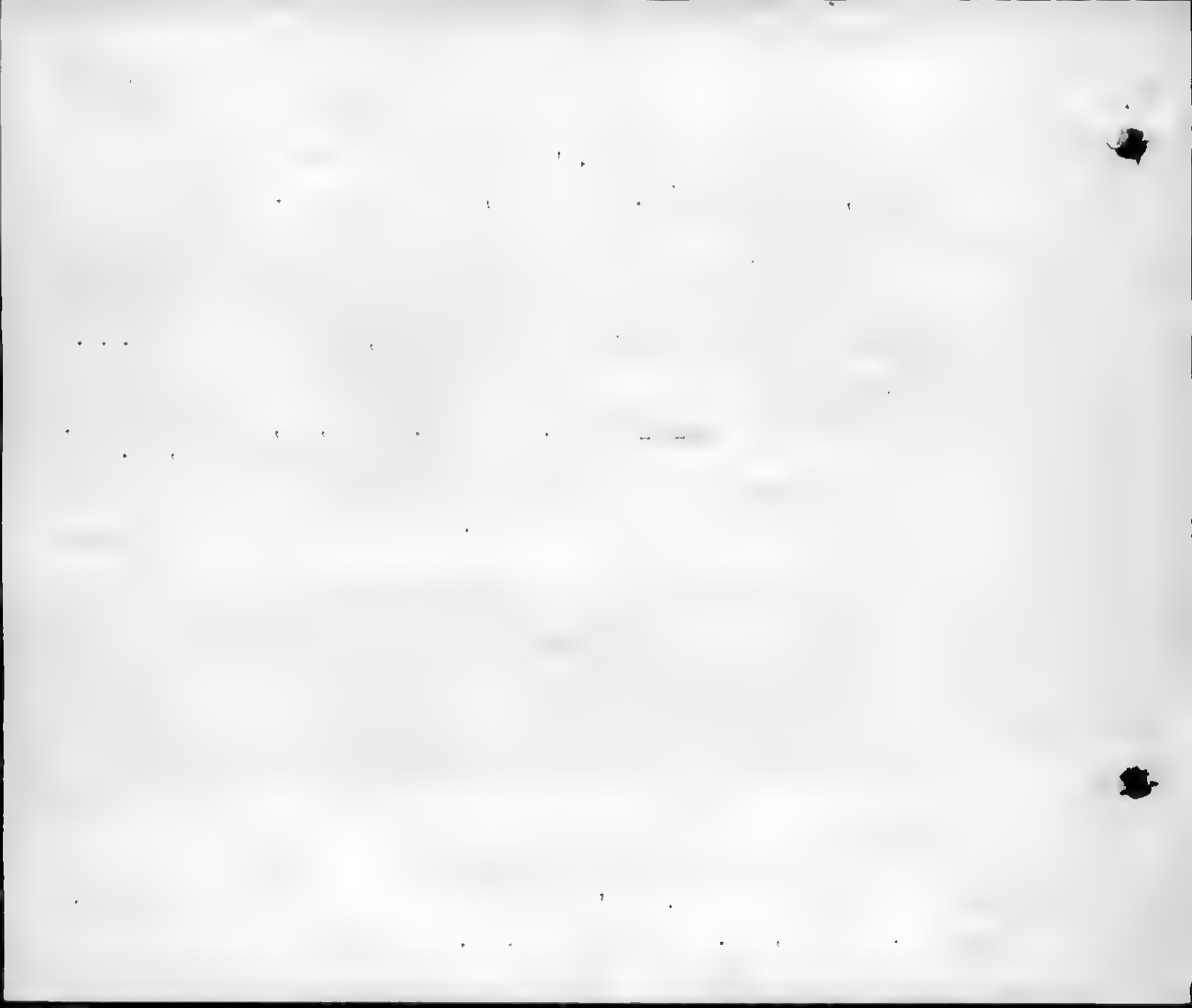
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4605
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04593

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b Since Nov. '60 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,306 BRUNSWICK AVE.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10,306 BRUNSWICK AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle NEWTON Last WOLFE		4. DATE OF DEATH Month APRIL Day 8 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/79
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 2 Days 12 Hours 12 Min.	11. IF UNDER 24 HRS Months 2 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) BAGGAGE AGENT		10b. KIND OF BUSINESS OR INDUSTRY RR Express Agency	
11. BIRTHPLACE (State or foreign country) Ijamsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE WOLFE		14. MOTHER'S MAIDEN NAME GEORGIANNA CLAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 714-07-9398	
17. INFORMANT Mrs. Charles J. Miller, 10,306 Brunswick Ave. Silver Spring, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute uremia DUE TO Cardio-vascular renal disease (b) Generalized arteriosclerosis (c) Bilateral pulmonary emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic hypertrophy	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 2 days 12 years 12 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1961 to 8 April, 1961 , that (I) (we) last saw the deceased alive on 7 April, 1961 , and that death occurred at A.M. from the causes and on the date stated above.			
22a. SIGNATURE C. Roger Kirtz, M.D.		22b. DATE SIGNED 4-8-61	
22c. PHYSICIAN'S NAME (Type) C. Roger Kirtz, M.D.		22d. ADDRESS 3701 Gun. Ave. NW. D.C.	
23a. BURIAL, CREMATION OR OTHER DISPOSITION (Specify) BURIAL		23b. DATE THEREOF 4/12/61	
23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATHOLIC CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WAGNER E. FUMAREY, INC. Raymond A. Zucka		25a. REC'D BY REGISTRAR APR 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMASCUS d. STREET ADDRESS 25111 RIDGE ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAZIE Middle MARIE Last WOODFIELD		4. DATE OF DEATH Month APRIL Day 27 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1890
9. AGE (In years lost birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WATKINS		14. MOTHER'S MAIDEN NAME EVIE LEE KING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-36-6962	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Mesenteric Artery Thrombosis with bowel necrosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Diabetic Mellitus, Senile Hypertension, Renal Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1953 to 4/27 1961 , that (I) (we) last saw the deceased alive on 4/27 1961 and that death occurred at 10 AM , from the causes and on the date stated above			
22a. SIGNATURE G. F. MEADORS, MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, MD		22d. ADDRESS DAMASCUS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-30-61	
23c. NAME OF CEMETERY OR CREMATORY Upper Seneca Baptist		23d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR MAY 2 '61	
ADDRESS Laytons ville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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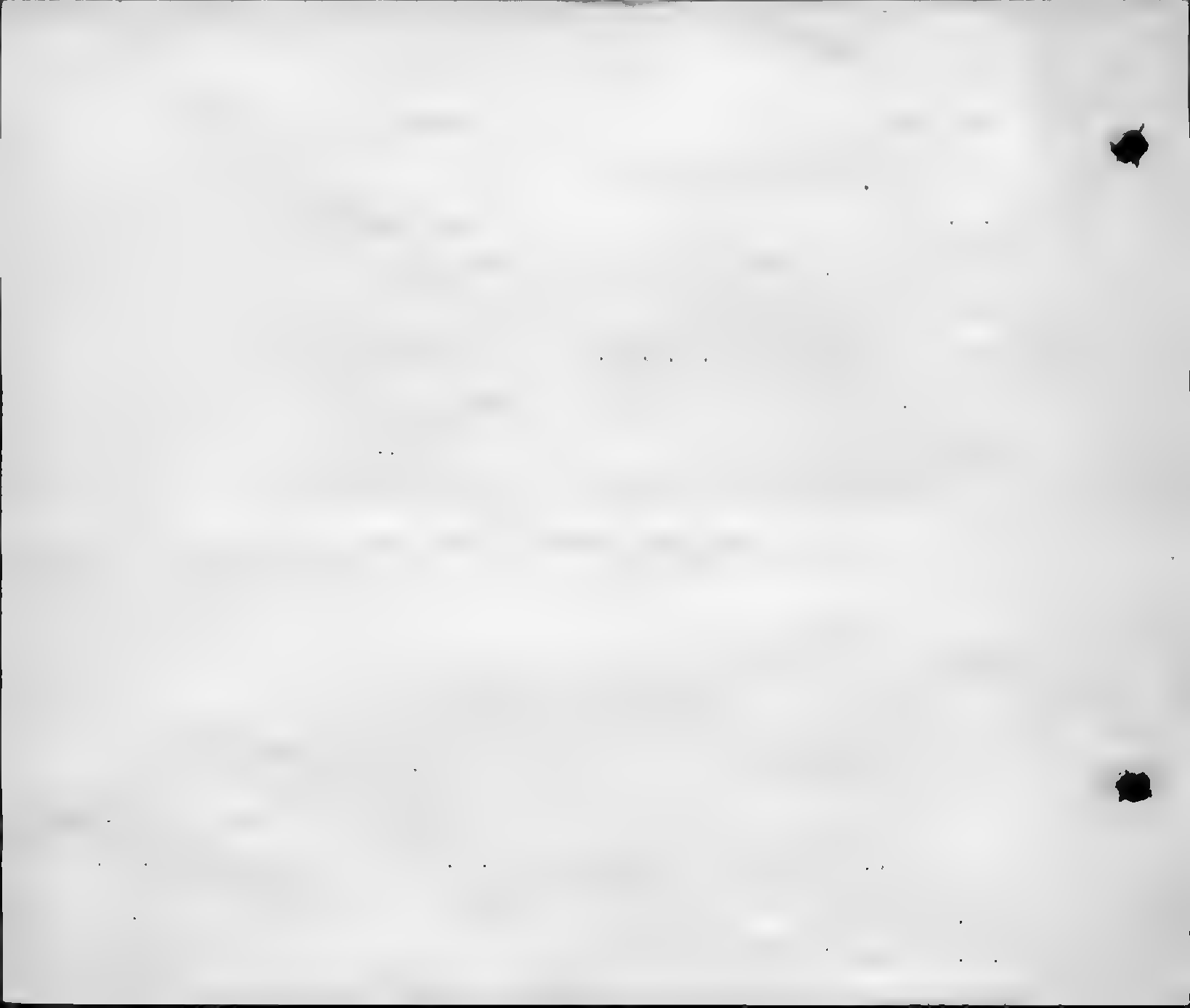
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2607
CERTIFICATE OF DEATH

04597

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY In b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 10329 Bethesda Church Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth Jack YOUNG		4. DATE OF DEATH April 28 19 61		5. AGE (In years last birthday) 42 yrs	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 2-16-19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Technician		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME George W. YOUNG		14. MOTHER'S MAIDEN NAME Mary HARR		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1944 to 1946		17. INFORMANT (W) Mrs. Ethel V. Young, same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease with</i> DUE TO (b) <i>aneurysm ascending aorta and aortic insufficiency</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I, or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 18 1961 to April 28 1961 that (I) (we) last saw the deceased alive on April 28 1961, and that death occurred at 1:45 PM, from the causes and on the date stated above.					
22a. SIGNATURE <i>J. E. Mc Clenathan</i>		22b. DATE SIGNED 4-28-61		22c. PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
Burial-Transit		4-29-61		Berkeley Springs Cemetery	
23d. LOCATION (City, town or county)		23e. (State)		23f. (County)	
Berkeley Springs		W. Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Humphrey</i>		24b. ADDRESS Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAY 2 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4608

04598

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5902 BEECH AVE.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 45 d. STREET ADDRESS 5902 BEECH AVE 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PHILIP L. ZEIGLER		4. DATE OF DEATH APRIL 12 1961	
5. SEX MALE	6. COLOR OR RACE CAUCASOID	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 8 Days 9	IF UNDER 24 HRS. Hours 9 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Salesman		10b. KIND OF BUSINESS OR INDUSTRY Brystal Myers	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Albert Zeigler	
14. MOTHER'S MAIDEN NAME Mary (Unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 083-05-7524		17. INFORMANT Mae M. Zeigler-Wife-Same 2d	
18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) CORONARY ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from FEB. 23, 1961 to APRIL 11, 1961 , that (I) (we) last saw the deceased alive on APRIL 11, 1961 , and that death occurred at 9:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph D. Connor M.D.		22b. DATE SIGNED April 12, 1961	
22c. PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR, M.D.		22d. ADDRESS 9420 OLD GEORGETOWN RD Bethesda, Md Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/61	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR APR 17 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

VR A15 (4)
15M 9/60

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George Albert Teller

00000-1000 Mrs. M. Teller - 1000-1000

George Albert Teller

George Albert Teller

George Albert Teller

00000-1000 Mrs. M. Teller - 1000-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

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(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
4609										
04599										
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 2 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital					d. STREET ADDRESS 2706 Upshur St.					
3. NAME OF DECEASED (Type or print) First Middle Last David Lewis ZIELSDORF					4. DATE OF DEATH Month Day Year April 26 19 61					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-24-61		9. AGE (In years last birthday) yrs. Months Days 2 2		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -					10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Henry ZIELSDORF					14. MOTHER'S MAIDEN NAME Arla Mae RADUE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Lewis H. Zielsdorf, same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from April 24, 1961, to April 26, 1961 that (X) (we) last saw the deceased alive on April 26, 1961, and that death occurred at 9:30AM, from the causes and on the date stated above.										
22a. SIGNATURE H. A. PEARSON LCDR MC USN					22b. DATE SIGNED 4-26-61					
22c. PHYSICIAN'S NAME (Type) XXXXXXXXXXXX, XXXXXXXX					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 4-27-61		23c. NAME OF CEMETERY OR CREMATORY Irving Township Cemetery			23d. LOCATION (City, town or county) Black River Falls Wisconsin			
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey					25a. REC'D BY REGISTRAR APR 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			
R. A. Pumphrey Funeral Home, Bethesda, Md.										

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